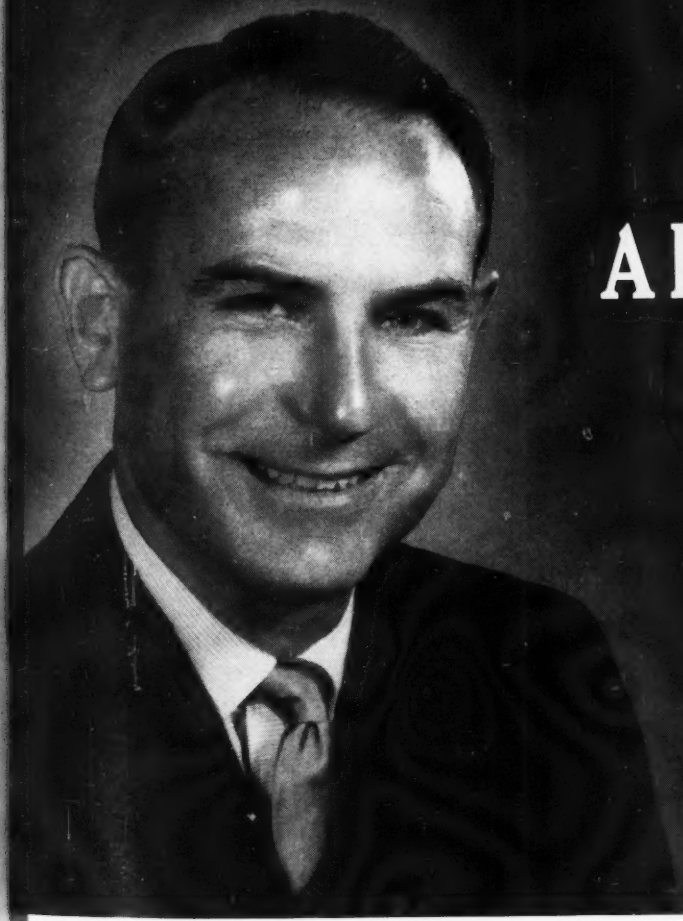
HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES



AHA CONVENTION REPORT ISSUE

FRED W. MOORE (see page 3)

BUYER'S GUIDE Page 66

OCTOBER | 1956

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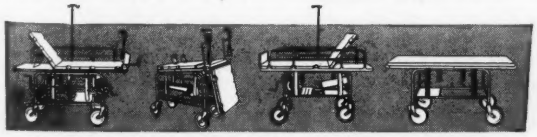

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HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

OCTOBER 1956, VOL. 34, NO. 10

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PERSONALITY OF THE MONTH

Fred W. Moore, president, California Hospital Association, was born in San Francisco and educated in California. He was in the surgical supply business for 10 years before he became administrator of Rideout Hospital, Marysville, Calif. 1946.

He has attempted to bring association activities and services to more members in small hospitals in the rural areas. In that way he hopes to build up a stronger, more cooperative association.

He has a keen interest in the California political situation relative to legislation affecting hospitals. When the California legislation is in session, the California Hospital Association reviews more bills affecting medicine and hospitals than the AHA does in Washington.

The liability insurance program of the California Hospital Association is the only state association-sponsored insurance program under which purchase and administration of insurance is controlled by the association. Mr. Moore has been a member of the insurance committee since its inception under the leadership of Ritz E. Heerman, general manager, Lutheran Hospital Society of Southern California.

Active in state hospital association work since he became an administrator, Mr. Moore was a member of the California Hospital Association's legislative committee in 1948-1949 and chairman from 1949-1953; member of the California Hospital Association's insurance council from 1954-1956; treasurer of the association from 1952-1953 and trustee from 1954-1955, and president this year.

He is married and has two daughters, 17 and 15 years of age. His hobbies are golf, fishing, and California Hospital Association activities. He is a Rotarian.

COMING NEXT MONTH

Basic Problems of Hospital Administration, by John H. Gorby

Problems of a Small Hospital Pharmacy, by Hazel Landeen

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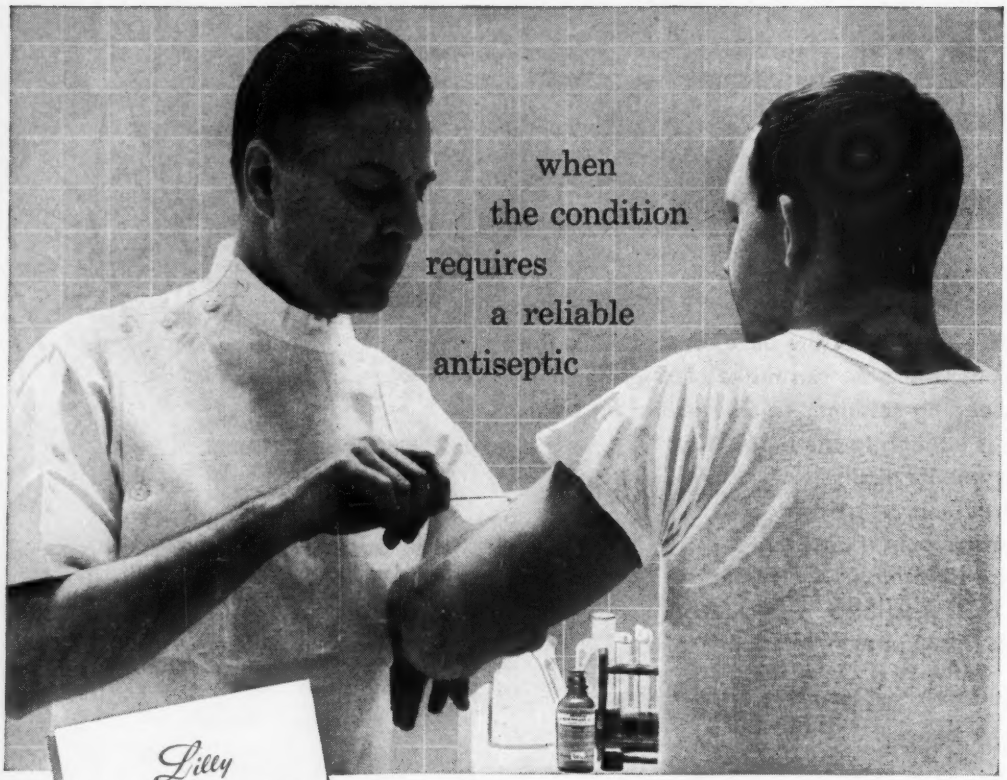

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HOSPITAL Topics
The News Magazine for the Hospital Staff

OCTOBER 1956
VOL. 34, NO. 10

Scanning the News

Emotional Stress in Pregnancy May Figure in Malformation

Emotional stress suffered during pregnancy may be a factor in development of malformations in babies, according to new tests performed by Lyon P. Strean, M.D., and Lyndon A. Peer, M.D.

If adequate supplies of vitamins and minerals are provided at the susceptible period of pregnancy, babies may develop normally.

About 232 cases of cleft palate and harelip were observed. Most of the mothers had suffered from various kinds of stress within the eighth and twelfth weeks of pregnancy. Severe emotional stress, particularly when associated with vomiting, was related to subsequent birth of a malformed child in 68 percent of the cases.

The doctors have suggested that perhaps a combination of stress and hereditary tendency is necessary to produce the abnormality, but it is not regarded as essentially hereditary.

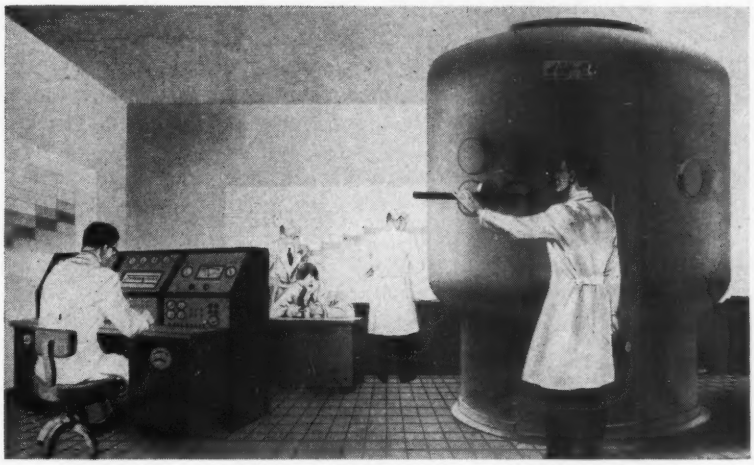
Conclusions were published recently in *Plastic and Reconstruetive Surgery.* Tests were performed at St. Barnabas Hospital Rehabilitation Center, Newark, N. J., and the Merck-Sharp & Dohme Research Laboratories, Rahway, N. J.

Eye Movements Indicate What You're Dreaming About

About two hours a night are spent in dreams by the average person. Dreams vary in length, and can last as long as an hour, according to Dr. Nathaniel Kleitman, University of Chicago, and Dr. William Dement, U. S. Public Health Service.

Eye movements during sleep are connected with periods of dreaming. Up-and-down eye movements are said to be connected with dreams of climbing, and side-to-side movements with dreams of horizontal activities.

Once a dream starts, body movements cease, except for minor ones such as finger twitching, until the dream stops.



Pictured above is the new nuclear reactor designed for use in hospitals and research centers. Safe, compact, and portable, the unit will fit into any laboratory without structural changes or additional shielding. The reactor will provide isotopes for clinical use. It will also be used to provide isotopes for general investigation and as a training facility to teach medical personnel reactor radioisotope technic.

Mosquitoes Prefer Dark-Skinned People

Mosquitoes prefer dark-skinned people, according to Dr. A. S. A. Brown of the University of Western Ontario.

He also says they do not like orange, yellow, green, or white, and show a strong liking for black, blue and dark red clothing.

World's Eating Habits Are Changing

Western Europe is consuming more fruit, milk, and cheese than before the war, according to E. O. Pollock, foreign agricultural service expert, Department of Agriculture.

Bread is replacing rice in some countries of Southeast Asia. In America the people are eating less grain products and potatoes and are eating more eggs, green vegetables, citrus fruits, and tomatoes.

Ultrasonic Vibrations Aid Writer's Cramp

Writer's cramp or pitcher's elbow can now be treated with ultrasonic vibrations and injections of hydrocortisone, reports John H. Aldes, M.D., Los Angeles in *GP.*

Ultrasonic vibrations increase blood supply, stimulate metabolism and assuage pain.

Environment Factor in Producing Neurotic Children

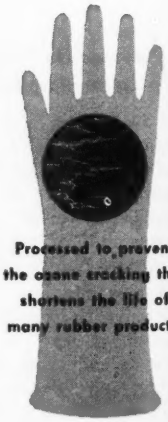
Environment is more likely than heredity to produce neurotic children, according to University of Illinois psychologists.

Prof. Raymond B. Cattell and his associates measured personalities of 600 normal 11-year-old children in Chicago, Boston, and New York. The results were tabulated on the Illiac, the university's electronic brain.

(Continued on page 133)

PIONEER's Exclusive Latex Formula Means More Sterilizations ...Lower Glove Cost

The superiority of PIONEER's Latex Formula in use is familiar only to those hospitals that use the PIONEER line. To them the hidden difference has become visible via more sterilizations and lower glove cost. Specify Rollprufs® or any of PIONEER's other glove styles, and see the difference in performance developed by PIONEER during 38 years of surgical glove research. Available from leading Surgical Supply Houses.



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News Briefs at Press Time

CENSUS BUREAU SURVEYS HOSPITAL UTILIZATION

A survey of hospital utilization in 637 counties was started by the Census Bureau the week of September 17. It will involve approximately 30,000 individuals in a cross-section of the population.

Analysis of results will provide detailed information hitherto unavailable on utilization by types, kinds, and classifications, and of outpatient departments, and will also provide information for the first time on the use of community hospitals by veterans.

OHIO VOTERS APPROVE $15 MILLION BONDS FOR HOSPITAL CONSTRUCTION

Voters in Columbus, O., on September 14 approved $15 million in general obligation bonds for construction of new hospital and nursing school facilities on land deeded to the county by participating hospitals.

After a 1954 survey revealed that the city's eight voluntary hospitals needed more than $25 million to meet minimum hospital bed and nursing school requirements by 1960, the Hospital Council concluded that the only way so much money could be raised was by recourse to the taxing power. To use that power for building or enlarging voluntary institutions required permissive enactment by the state legislature.

Seven Ohio hospitals which had been built by city or county funds were subsequently leased for operations by voluntary nonprofit associations. Permission was obtained, with approval of the voters, to erect such buildings, or hospital wings, for the express purpose of leasing them at a nominal sum for a 50-year term, with privilege of repurchase at depreciated values.

To supplement the $15 million, a public campaign is in progress to raise $5.6 million. To this, according to Harrison M. Sayre, president, Columbus Hospital Federation, will be added nearly $3 million from earlier gifts, bequests, and reserves, and an estimated $2-$3 million from loans.

REGULATION ON DEPENDENTS' CARE CLEARED FOR WHITE HOUSE APPROVAL

Regulations for medical care of servicemen's dependents, after much revision, have been cleared by Secretary of Defense Wilson for President Eisenhower's approval.

Meanwhile, AHA House of Delegates, at Chicago convention, though unhappy with division of hospital coverage between Blue Cross and commercial insurance companies, still voted complete cooperation with program, and even urged that Blue Cross billing rates be used in states allocated to commercial companies, to save the government money. For further information, see AHA report—p. 17.

PHS SCHEDULES SICKNESS SURVEY FOR MARCH START

Public Health Service's house-to-house survey of illness and medical care expenditures is scheduled to begin next March.

Survey, to be conducted by specially trained Census Bureau personnel, will cover 12,000 families in first four months of field work. Beginning in July, 1957, monthly sampling will be gradually increased, until it reaches 3,750 a month by end of year.

First special study, as distinguished from routine survey of sickness (which will continue), will ask for medical examinations of persons selected from the household canvass.

BRIEF BRIEFS

Medical care cost ranked second in August among all consumer items, housing, and services, according to latest consumer price index. Public transportation was first . . . New hospital at Wright-Patterson AFB in Ohio was dedicated September 21 by Surgeon General Dan C. Ogle, who implied that volume and diversity of medical care in his service may call for re-evaluation of system, with consideration being given to establishment of medical centers comparable to those operated by Army, Navy, and PHS . . . Office of Vocational Rehabilitation awarded $1,729,942 in training grants to institutions and individuals in fiscal year which ended June 30.

Gordon M. Marshall

Calendar of Meetings

OCTOBER

8- 9 South Dakota Hospital Association
Sheraton-Johnson Hotel, Rapid City, S. D.

8- 9 Oregon Association of Hospitals
Hotel Senator, Salem

8-11 American Academy of Pediatrics
Hotel Statler, New York

8-12 American Society of Anesthesiologists, Inc., Kansas City Auditorium

8-12 American College of Surgeons, Clinical Congress, Fairmont Hotel, San Francisco

9-12 American Dietetic Association
Auditorium, Milwaukee, Wis.

9-13 American Society of Clinical Pathologists, Drake Hotel, Chicago

10-11 Washington State Hospital Association, Chinook Hotel, Yakima, Wash.

10-12 Montana Hospital Association
Florence Hotel, Missoula

14-17 Indiana State Medical Association
Murat Temple, Indianapolis, Ind.

14-17 Medical Society of Virginia
Hotel Roanoke, Va.

14-19 American Academy of Ophthalmology and Otolaryngology,
Palmer House, Chicago

15-19 AHA Medical Record Library Personnel Institute, Hotel Jefferson, Richmond, Va.

16-18 Associated Hospitals of Alberta
MacDonald Hotel, Edmonton

16-19 Oregon State Medical Society
Masonic Temple, Portland, Ore.

17-18 Vermont Hospital Association
Pico Peak, Long Trail Lodge, Rutland

17-19 American Association of Hospital Accountants, Florida chapter, Institute on Accounting, Daytona Plaza Hotel, Daytona Beach, Fla.

18-19 Mississippi Hospital Association,
Hotel Edwards, Jackson, Miss.

21-26 Medical Society of Pennsylvania
Haddon Hall, Atlantic City, N.J .

24-25 Indiana Hospital Association
Student Union Building, University of Indiana Medical Center

24-26 California Hospital Association
St. Claire Hotel, San Jose

25-26 Nebraska Hospital Association
Hotel Fontenelle, Omaha

27-28 American College of Osteopathic Hospital Administrators, Sheraton-Cadillac Hotel, Detroit, Mich.

28-31 Annual Convention, National Society for Crippled Children and Adults
Hotel Statler, Washington, D. C.

28-31 American Osteopathic Hospital Association, Sheraton-Cadillac, Detroit, Mich.

31- 2 Maryland, D.C., Delaware Hospital Association, Shoreham Hotel, Washington, D.C.

NOVEMBER

5- 7 American College Obstetrics-Gynecology, Palmer House, Chicago

5- 9 AHA Nursing Service Administration Institute, Sheraton-Gibson Hotel, Cincinnati

6- 7 Colorado Hospital Association
Broadmoor Hotel, Colorado Springs

8 IHA Methods Improvement Institute
Bradley University, Peoria, Ill.

8- 9 Oklahoma Hospital Association
Skirvin Hotel, Oklahoma City

9 Minnesota Hospital Association
Hotel St. Paul, St. Paul, Minn.

11-14 Assoc. Military Surgeons of the U. S.
Statler Hotel, Washington, D. C.

11-15 Southern Medical Association
Sheraton-Park Hotel, Washington, D.C.

12-16 American Association of Inhalation Therapists, Park-Sheraton Hotel, New York City

12-16 American Public Health Association
Convention Hall, Atlantic City, N. J.

15-16 Kansas Hospital Association
Baker Hotel, Hutchinson

15-17 Arizona Hospital Association
Westward Ho Hotel, Phoenix

15-20 American Surgical Trade Association
24th Regiment Armory, New York

16-17 Virginia Hospital Association
Hotel Roanoke, Roanoke, Va.

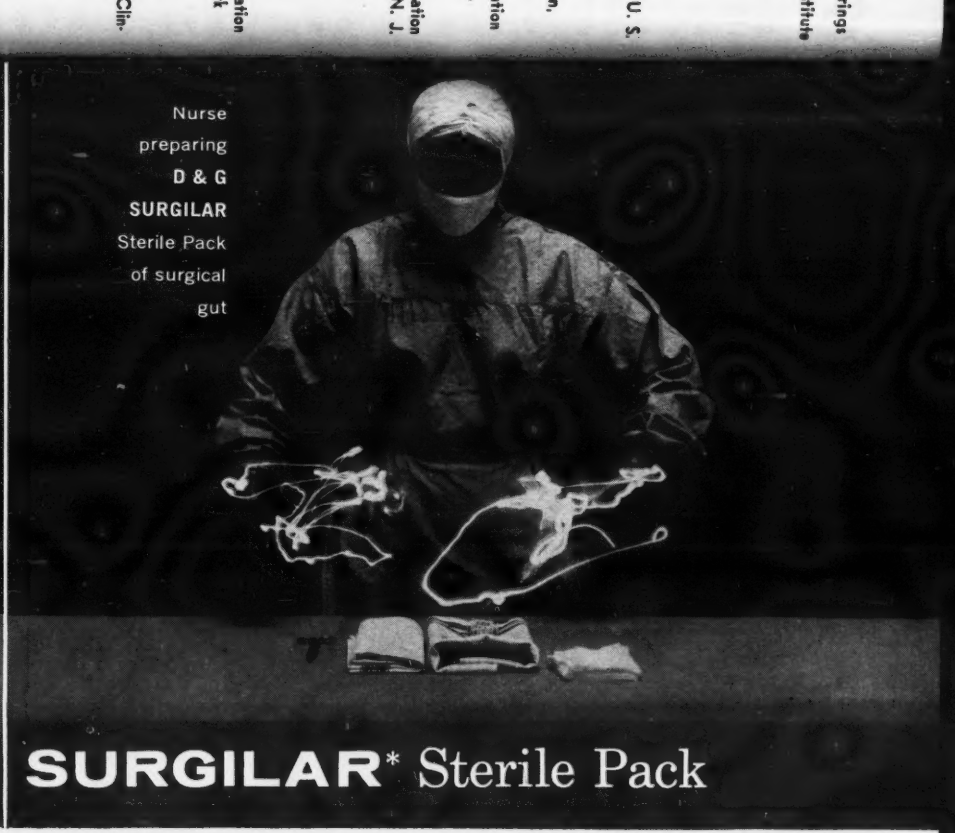
27-30 American Medical Association, Clinical Meeting, Civic Auditorium, Seattle

DECEMBER

6- 7 Illinois Hospital Association
Hotel Abraham Lincoln, Springfield, Ill.

8-13 American Academy of Dermatology and Syphilology
Palmer House, Chicago

Nurse preparing gut in glass tubes



Nurse preparing **D & G SURGILAR** Sterile Pack of surgical gut

Save suture handling with **D & G** **SURGILAR*** Sterile Pack

GET BROKEN GLASS OUT OF THE O.R.

Light-tracings in the time-and-motion pictures show a nurse's hands at work. Compare the simple motions she uses to prepare SURGILAR Sterile Pack of surgical gut with the many motions for tubed gut. She can handle SURGILAR ⅓ faster than tubes.

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With SURGILAR, double envelopes are quickly cut, gut easily withdrawn, ready for use. No need to wash plastic envelopes after exposure, since they are protected by the outer envelopes. Jars store in ½ space required for tubed gut.

photo technic: *light-tracings of hands to which bulbs are attached.*

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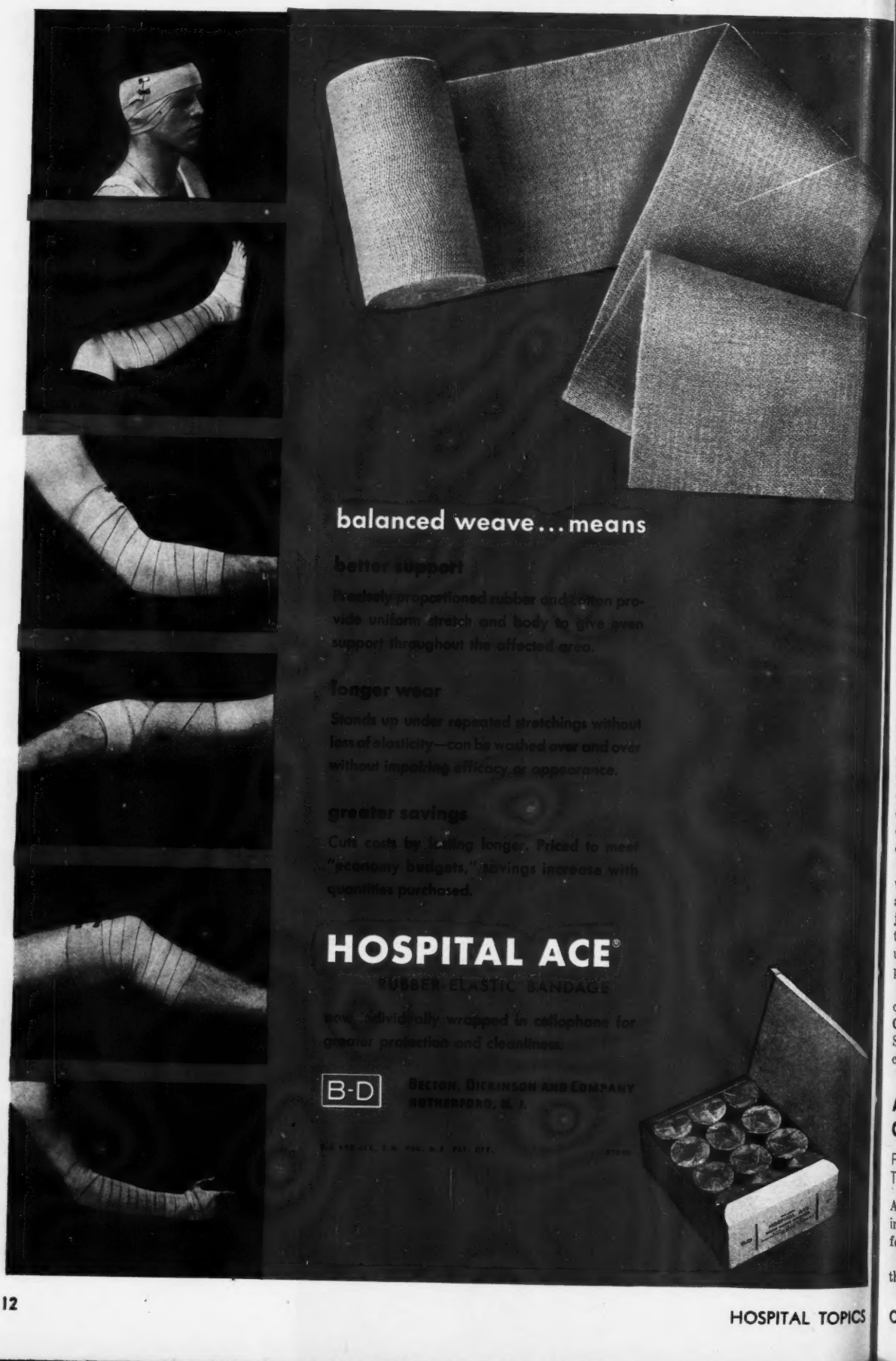
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Stands up under repeated stretchings without loss of elasticity—can be washed over and over without impairing efficacy or appearance.
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RUBBER ELASTIC BANDAGE
now individually wrapped in cellophane for greater protection and cleanliness
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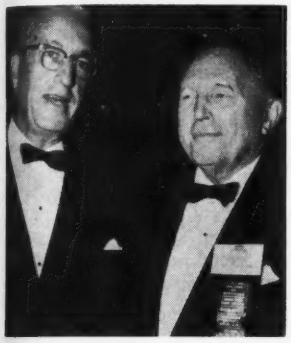
Breast Cancer Survival Rate Reported at Int'l College of Surgeons

• Over 5,672 surgeons and guests from all parts of the free world attended the four- day combined 10th biennial congress of the International College of Surgeons and the 21st annual congress of the United States and Canadian Sections held in Chicago, recently.



Left: Arnold S. Jackson, M.D., Madison, Wis., past president, United States Section International College of Surgeons, exchanges views with Adm. Ross T. McIntire, USN (ret.), executive director, International College of Surgeons, Chicago, at the social hour preceding the annual banquet.

Unnecessary Hysterectomies Are Too Widely Publicized

M.D.'s Judgment More Important Than Absence of Diseased Tissue

The hysterectomy is a form of definitive treatment, and it does ally fear; not so with repeated curettages, in climacteric and post climateric women who are bleeding. Prompt action has considerable merit because, through our own education programs, we have created a state of real cancerphobia—a present-day fear of such frequency and often of such magnitude that it cannot be disregarded.

A physician's judgment is more important in deciding whether a hysterectomy should be performed than is the absence or presence of diseased tissue in the uterus. This judgment is based on repeated interviews with the patient to find out how she would feel about removal of the uterus and whether surgery would eliminate her complaints.

Hysterectomy should not be done for simple nervous complaints or for purposes of sterilization.—**George H. Gardner, M.D.,** Professor of Obstetric and Gynecologic Surgery, Northwestern University Medical School, Chicago.

Artificial Limbs for Children Under One

Follow-Up Visits Important To Assure Correct Use

Artificial arms and legs are being fitted on child amputees in the first year of their lives, at the University of California Medical Center, Los Angeles.

The child-amputee prosthetic program is conducted by the medical school and the college of engineering. The medical school is responsible for diagnosis and treatment; the engineering college for production of devices needed by patients.

Work is carried on by an eight-member team consisting of: Orthopedist, pediatrician, psychiatrist, physiologist, physical therapist, social worker, limb fitter, and amputee trainer.

The study, fitting, and training of 100 children with different types of amputation showed:

(1) The psychological effects of amputation on child and parent is of much greater magnitude than previously thought.

(2) A teaching program for use of prosthetic devices is necessary, with regular follow-up visits to assure proper fit, use and comfort of prostheses.

(3) A conservative attitude toward surgery is urged. Growth centers should be preserved, if possible, and all possible length retained. Cineplasty is rarely indicated before child is 15.

(4) Scaled-down models of adults' prosthetic devices are not entirely satisfactory for children. Special devices have been found helpful.—**Robert Mazet, Jr., M.D.,** Associate Clinical Professor of Orthopedics, and **Milo B. Brooks, M.D.,** Clinical Professor of Pediatrics, University of California School of Medicine, Los Angeles.

Increased Survival Rate For Breast Cancer

Internal Lymph Node Chain Removed in Extended Surgery

Removal of the internal mammary lymph node chain will prevent recurrence of cancer in an increased number of patients.

It has been the practice in treating breast cancer to remove the lymph chain leading to the armpit. In the extension of this surgery, the chain along the internal mammary artery within the chest is also removed.

This operation was performed on 235 patients with less than one percent postoperative mortality. Thirty-five percent would have had metastasis if they had been treated by classical radical breast-removal procedure.

In the first 70 primary operable breast cancers undergoing this procedure, there was a three-year survival rate of 81 percent.—**Jerome A. Urban, M.D.,** Instructor, Cornell University Medical College, New York City.

(Continued on next page)

Above: Professor D. Travlos, M.D., professor of surgery, National University of Athens School of Medicine, Athens, Greece, with Robert Karen, M.D., Milwaukee, Wis., and Mrs. Karen.

Future Plans Say Patient May Leave Under General Anesthetic

Nursing Requirements
Will be Lessened

In the future a patient may walk into a hospital, be operated on under a general anesthetic, and then leave after the effects have worn off.

General anesthesia also may be used in office practice.

Faster postoperative recovery will lessen nursing requirements in hospitals. Advent of tranquilizing drugs has made it possible for a patient to sleep well before the operations. Sleep is needed to better tolerate the stress of anesthesia and operations.—**John S. Lundy, M.D.**, Professor of Anesthesiology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minn.

Above: Harry J. MacMahon, M.D., chief consultant, ENT, Mercy Hospital, Buffalo, N.Y., and Mrs. MacMahon pause before entering the grand ballroom for the 21st annual banquet, at which Cardinal Stritch, Archbishop of Chicago, spoke on "The Surgeon in His Treatment of the Whole Patient".

Rib Cartilage Used To Produce Ear

Found 80% Effective

Diced cartilage from ribs, kept in a mold buried in the abdominal wall, is being used successfully in construction of missing ears.

The diced grafts are put into a perforated vitallium ear mold and the halves of the mold fastened together, pressing cartilage segments into the form of an ear. Mold is put into a pocket beneath the patient's abdominal skin, and pressure dressing applied to keep it firmly in place.

The mold remains for five months. During this time tissue grows through openings in the mold and fastens separate diced cartilage segments together. When the mold is removed from patient's tissues, and the two halves separated, cartilage ear framework has been formed by nature's healing process.

Cartilage framework is inserted in the pocket in the region of the absent ear and skin is pressed against the framework which produces a flat ear. Later the framework is separated from the side of head and the back part covered with a skin graft taken from the abdominal wall.

Satisfactory results were obtained in 80 percent of 65 ear constructions. The majority of failures occurred in early operations. Satisfactory results were obtained in nine out of 10 cases in the last year—**Lyndon A. Peer, M.D.**, head, Peer Clinic for Plastic Surgery, Newark, N.J.

Study Malformations Of Heart, Great Vessels

Anomalies are
Due to Arrest, Overgrowth

Malformations of the heart and great vessels represent two patterns of abnormal local development: arrest and overgrowth. Anomalies due to local arrest in growth consist in persistence of fetal communications and passages, representing an earlier stage in fetal development. Periods of local arrest can be preceded or followed by temporary overgrowth producing combined cardiac defects.

Anomalies due to local overgrowth are abnormal narrowing at some points in passages for blood flow. They do not represent any stage of normal fetal development.

Arrest of development is caused by anoxia in fetal tissues, animal experiments have proved. It is postulated that overgrowth is result of hyperoxygenation of fetal tissues. A possible method to increase oxygen supply temporarily to cardiac tissues may be to increase carbon dioxide level in the blood and shift the oxygen dissociation curve to the right.—**Olga L. Haring, M.D.**, research associate in cardiology, Chicago Medical School.

Below: Jiro Arakawa, M.D. (center), head, Arakawa Surgical Hospital, Tokyo, Japan, with Harry Hata, M.D., Chicago, and Mrs. Hata.

Radical Surgery Advocated For Breast Cancer

Well-Directed Radiotherapy Used in Conjunction

More radical surgery and well-directed radiotherapy are currently being favored in treatment of breast cancer in France. The classical methods have not proved satisfactory.

Radical surgery done in Grenoble and Paris, under the direction of Redon, involved the ablation of the internal mammary nodes.

Cancer radiotherapists believe that breast cancer radiotherapy has been conducted in insufficient doses.

The minimum dose is 6,000 r. for tumors.—**Jaques Brenier, M.D.**, Grenoble, France.

Rice Diet in India Blamed for Ulcers

Diet Deficient in Fats and Proteins

A heavy rice diet may be a contributing factor in the high incidence of peptic ulcers in the stomach and the duodenum in India. This is particularly true among the poorer, working classes, whose mainstay is rice because fish and eggs are too expensive and milk products are available to only a few.

A rice diet is irritating to the stomach and deficient in fats, proteins and vitamins.

In northern India, where a wheat diet is used and rice comes into the picture only occasionally, peptic ulcers occur less frequently.

Of 2,500 patients treated at the government general hospital, Madras, over the last 30 years, only five percent came from the middle and upper classes. Ninety percent were in the third and fourth decades of life. Ulcers in the duodenum were 15 times as common as ulcers in the stomach.—**K. G. Pandalia, M.D.**, President, Indian Section, International College of Surgeons, Madras, India.

Cobalt in Sutures Halts Spread of Bladder Cancer

Supplies More Accurate Radiation To Localized Area

Radioactive cobalt in the form of nylon sutures is being used as a barrier to the spread of cancer of the bladder.

This procedure, used for four years, has been applied to 22 patients. Five have died—two from causes other than cancer, and three from cancer which has spread to the liver. One is alive a year after surgery, but is believed to still have the disease. The other 16 are well and have been free from disease for three months to four years.

The 16 patients treated with radioactive cobalt whose lesions are confined to the bladder wall now have normal bladders and void normally.

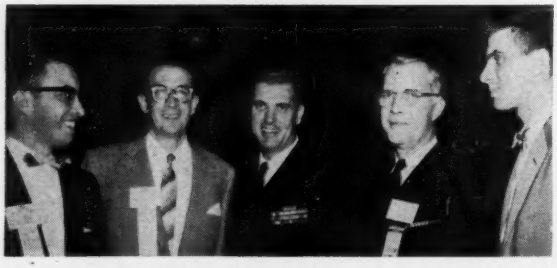
With radioactive cobalt in nylon suture form, the cancer of the bladder can be destroyed at its outer margin, where it is actually invading tissue. In this form, the cobalt supplies a more accurate radiation to a localized area, and achieves results obtained by total removal of the bladder. And the patient is left with a normal urinary tract.—**Vincent Vermooten, M.D.** Associate Professor in Urology, University of Texas Southwestern Medical School, Dallas.

(Continued on next page)

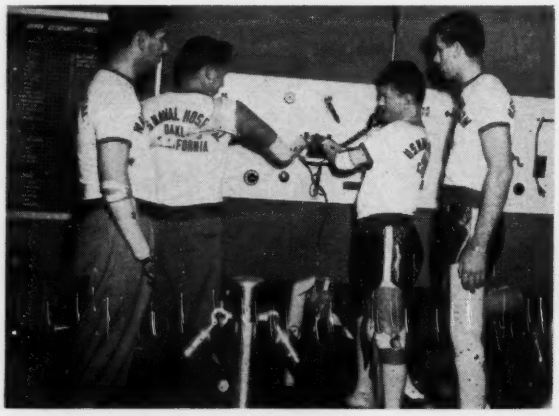
Upper right: Maria Dulce Albuquerque, Salles, Bahia, Brazil, chats with Treiste Smanio, M.D., Sao Paulo, Brazil, at the social hour preceding the annual banquet.

Right: K. G. Pandalai, M.D., (center), Madras, India, former professor of surgery, Madras Medical College, and president, Indian section, International College of Surgeons; H. R. Doctor, M.D., surgeon, J. J. Hospital, and Bombay Hospital, and Mrs. Pandalai.

Above: Comdr. T. J. Canty, M.C., USN, Amputation Center-U.S. Naval Hospital, Oakland, Calif. (l.), and Lt. Comdr. Charles C. Asbelle, supervisory rehabilitation specialist (r.), brought a group of men from the Center to help staff the special booth. Pictured with Comdr. Canty and Lt. Cdr. Asbelle are (l. to r.): Corbit Ray, Rogelio Hernandez, Albert Wenger, and David Backman. Pictured in the display are the hook used for a work device, and the covered hand, for cosmetic purposes, a special attachment enabling an amputee to control a bowling ball, hold a tennis racket, or adapt it for use on a hunting rifle, a woman's leg that has been matched to neutral skin tones. Pancake make-up can be used to vary the color throughout the year. The items in the display were part of the 30 projects on which the navy is now working.



Above: Napoleon Rojas, M.D., and Serano Fernando, M.D., plastic surgeons of Bogata, Colombia, are now visiting the USN Amputation Center in Oakland, to study the new technics being used. Pictured with the Colombian doctors are Lt. Cdr. Charles Asbelle, Comdr. Canty, and David Backman, instructor, Amputation Center.



Above: Albert Wenger shows (l. to r.); Rogelio Hernandez, Corbit Ray, and David Backman how to use the dial phone; the phone is one of the items on the training gadget board.

Sterility Corrected Following Vasectomy

Previous Attempt
Not Contraindication

Sterility following vasectomy was corrected successfully by anastomosis of vas deferens in 90 percent of the 20 cases reported.

A previous unsuccessful attempt at vasorrhaphy is not a contraindication to re-operation, as evidenced by successful results in five or six patients subjected to re-operation. Surgical acclusion of the vas does not appear to abolish supermatogenesis. Normal sperm were observed in one patient 19 years after vasectomy.

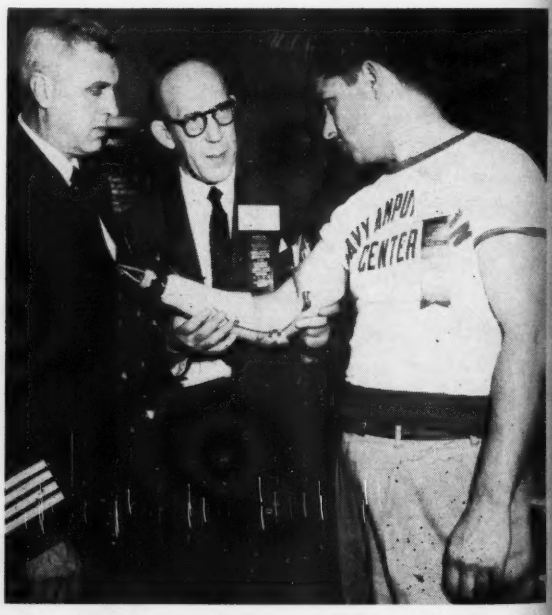
Epidiymo-vasorrhaphy should be attempted when anastomosis of the vas deferens is not technically feasible.—**John W. Dorsey, M.D.**, senior attending surgeon in urology, Harbor General Hospital, Long Beach, Calif.

Results of Treatment For Urinary Tract Infections

Routine Microscopic Tests
Sometimes Misleading

In the treatment of 61 of 100 patients with uncomplicated clinical urinary tract infections, excellent correlation between in vitro disk susceptibility tests and clinical results with Furadantin therapy was observed with few exceptions.

Reliance on routine microscopic observation of urine, or leukocyte incidence per H.P.F. as index of infection, can be misleading. There were six instances of Furadantin intolerance, but the reactions were all mild and gastrointestinal in nature.—**Lowrain E. McCrea, M.D.**, Clinical Professor in Urology, Temple University School of Medicine, Philadelphia.



Above: Comdr. T. J. Canty, M.C., USN, explains the Navy cineplastic artificial arm of Rogelio Hernandez to Pierre Jonescu, M.D., visiting surgeon from London, England.

Report on the AHA

•Almost 11,000 attended the 58th annual convention of the American Hospital Association held in Chicago's International Amphitheatre September 17-20.

Named president-elect was Tol Terrell, administrator, Shannon West Texas Memorial Hospital, San Angelo, Tex. The 1957 meeting will be held in Atlantic City.

Below: In picturesque setting of nearby Stock Yard Inn, president Ray E. Brown (center), past president Ritz E. Heerman (l.), and Maurice J. Norby, AHA deputy director, examine the special "HIA Convention Guide to Chicago," sent out to all hospitals in the nation by the Hospital Industries' Association.

Please turn page for TOPICS' convention report.

Doctors' Insecurity, Fear Blamed For Differences with Hospitals

Contractual Relationship, Other Disputes Called Symptoms of Basic Issues

Most of the differences between hospitals and physicians can be related to two issues. One has to do with the insecurity of the physician, who must depend upon facilities he does not own and upon personnel he does not employ. The second issue is the fear of the physician of any circumstances that might restrict his right to professional freedom in the practice of his profession.

Failure to stick with the basic issues has not only produced unnecessary frictions but has handicapped important developments in the health field, such as prepayment coverage, medical education, and hospital accreditation. Among other things, it has led to the bewildering attempt to define precisely what constitutes the practice of medicine.

The differences that have received wide publicity, such as the contractual relationship between hospitals and the full-time physician-specialist, are symptoms of the two basic issues.

Hospitals and physicians should determine the limits which must be recognized in making changes in the pattern of medical care distribution. These limits should be those which protect the fundamental purposes and nature of either the profession or of the hospital. On the part of the hospital, these are:

(1) The responsibility to provide as complete and integrated institutional medical care as community resources will permit; (2) a responsibility to maintain the highest possible level of patient care and to assure that all care will at least meet minimum standards; (3) a responsibility to provide patient care as effectively and economically as possible.

On the part of the physician, these are:

(1) A duty to protect his professional integrity, the right to independent medical decisions; (2) the privilege to use hospital facilities within the limits of his training and in keeping with acceptable professional conduct; (3) the right to have his professional competency and conduct determined by his medical peers and to participate in decisions affecting professional practice within the hospital.

If hospitals and physicians agree on some such set of criteria, the problems affecting their relations will yield to harmonious solution. Solutions forced by recourse to courts, by economic pressures, or by professional boycott cannot survive.—**Ray E. Brown,** Immediate Past President, American Hospital Association, and Superintendent, University of Chicago Clinics.

Hospitals Can Be Rehabilitation Centers at Small Additional Cost

Nurses Can Start Ball Rolling; Therapists, Social Workers Used

A hospital can create and generate rehabilitation services from its present staff, at little additional cost.

The first group an administrator can indoctrinate and train in this philosophy is the nursing service. With little training, nurses can put joints through a normal range of motion, thus avoiding and overcoming joint stiffness and contractures.

The nurse can be taught to train the patient to control his bladder and bowels. The time spent in training is much less than that required to change linen of an incontinent patient. She can teach severely disabled patients to dress and undress and to take care of simple hygiene. Bed positioning and the prevention and care of decubitus ulcers are easily within the realm of good bedside nursing.

Each hospital of over 50 beds could well justify employing a physical therapist. He could take over where the nurse's training is deficient in muscle re-education, walking training, and more advanced physical restoration.

Social workers, speech therapists, and vocational counselors, are usually available in other agencies and could be recruited on a part-time basis.

The physician must be indoctrinated slowly and carefully. The administrator will have to take the lead. The physician will accept the service when he sees that his patients are benefiting.

For a small investment, the physical plant can be changed so that the area set aside for rehabilitation services is more conducive to the care of long-term patients.

A recreation room which can be used for community eating leads to socialization. Minor changes in bathrooms to accommodate wheel chairs and make sitdown showers possible are not too costly. The use of four-bed wards rather than single or double rooms is more conducive to rehabilitation services.

The work of rehabilitation centers will be simplified if each community hospital accepts its responsibility in the early care of the chronically ill.

If voluntary medical facilities provide services at cost and these services are going to result in reduced public expense, I believe a hospital will have no trouble selling the service to a public body.—**Joseph N. Schaeffer, M.D.,** Associate Medical Director, Institute of Physical Medicine and Rehabilitation, Peoria, Ill.

Mental Health Commission Seeks Better Use of Resources

Expects to Develop Program For Improved Patient Care

The Joint Commision on Mental Health and Illness hopes to be able to suggest better methods of making use of current resources for mental care and to point to needed new activities.

Its three-year research will cover, among other things, the following:

(1) Numbers and kinds of mental patients treated.

(2) Prevalence of mental illness, symptoms, worries of patients, stresses, and agencies to which patients turn.

(3) Detection and treatment of mental illness in the early or presymptomatic stage and the treatment of mental disease in outpatient clinics and hospitals.

(4) Effect of hospital staffing and organization on the output of patients.

(5) Administrative structure of hospitals, the role of various hospital personnel, the function of employees, and their effect on behavior and discharge rates.

(6) Mental health practices in schools and their effect on children.

(7) Availability of professional people, the needs for them now and in the future, and the training resources necessary to produce the required number.

(8) Research activities in mental health promotion and treatment.

(9) Research facilities available and an estimate of future needs.

(10) Effect of laws on the organization and rendering of services devoted to the care of the mentally ill.

(11) Role of family and groups in mental health promotion.

(12) Role of industrial health services and unions — **Jack R. Ewalt, M.D.,** Director, Joint Commission on Mental Health and Commissioner, Massachusetts Department of Mental Health, Boston.

(Continued on page 20)

Delegates' Action

AHA Delegates took the following action:

Recommended that member hospitals use Blue Cross reimbursement formula, rather than billings, in providing hospital care to servicemen's dependents, even in areas allocated to commercial insurance companies. Outgoing president Ray E. Brown had told the House that the government decision to split the dependents' hospital care program between Blue Cross and commercial companies was "very bad judgment."

Approved a statement recommending that Congress enact definite legislation to provide hospital and medical care for future veterans with non-service-connected disabilities, "if such veterans are declared to be eligible and . . . need of care is established within a limited period . . . after their separation from service."

Approved a recommendation that the AHA board of trustees consider an organized fund-raising campaign to obtain voluntary contributions for association's building fund.

Passed a resolution of gratitude to the Ford Foundation for its grants.

Sumner Price, M.D., administrator and medical director, The Queen's Hospital, Honolulu, Hawaii, stops after busy delegates' session to examine new books at HOSPITAL TOPICS' booth.

Giving Industry Voice in Hospital Planning an Encouraging Trend

Suppliers of Funds Should Have
Word in Determining Expansion

Hospitals have turned to local industrial concerns for an important share of capital funds. Modern corporations recognize their responsibility to contribute to the development of adequate health facilities in the community in the same way they contribute to prepayment plans for their employees.

Industry knows that unless hospital construction is based on known facts and is soundly planned, there is danger of overbuilding at the very time when maximum use of existing facilities and available personnel is far from realized.

Too many beds will create very quickly a deficit financing problem for the community and will cause havoc in prepayment plans—both Blue Cross and commercial insurance. The hospital with empty beds will do everything possible to fill these beds with patients. Unnecessary admissions will be the order of the day. This in itself could bankrupt any prepayment program. Too many beds will obviously pit hospital against hospital in a vicious type of competition for patients.

Orderly, planned expansion is another matter. Some communities still lack sufficient hospital facilities to meet the demand, and in others additional capital invested in modern facilities would reduce the costs of adequate services.

Industry is asking a logical and simple thing in requesting to be a part of such planning, to have a voice in it, to have assurance that what's being projected is in the best interests of the entire community, and is not just indulging the sentiment of a particular group which wants to erect a monument to its community activities.—**Nathan J. Stark,** Board Member, Kansas City Area Hospital Association, and Vice-President, Rival Manufacturing Co., Kansas City.

Many Forces Are Creating Demands For New Patterns in Medical Care

Research in Hospital Facilities
And Services Regarded Essential

Many forces are creating demands for new patterns in medical care. Medical research produces new knowledge about preventive medicine and rapid cure. Rehabilitation concepts and programs develop and expand. The rapid growth of voluntary hospital insurance has increased the demand for hospitalization. The public's concern with health and medical affairs is increasing constantly.

Research in hospital facilities and services is essential. It is a neglected field compared with medical research—and one of great possibilities. In the past two years, $2.4 million has been appropriated by the Public Health Service for research grants for this purpose. Studies are now under way to uncover knowledge about a wide range of problems in the hospital field.

More thought must be given to rational distribution of expensive personnel, with patients grouped in facilities according to the degree of their illness. We must use more imagination in designing hospitals and in organizing services to fit patients' needs.

I hope hospitals will experiment with possible ways of allowing patients to perform more services for themselves. The Public Health Service is gathering information on experiments with self-service ideas. When this information is analyzed, the Service, with the help of outside consultants, will plan specific research.

There also is need for studies of various types of laboratory services, and for experiments with home-care programs, day hospitals, night hospitals, and "half-way" houses.

New approaches to current questions about nursing homes are essential. Hospital administrators and boards may be expected to take the initiative in stimulating community action in this field.

Methods of meeting hospitalization costs must be improved. Voluntary insurance should be able to cover costs of long-term and other expensive illness, and would be desirable also for prepaying costs of care in nursing and convalescent homes. There is a great unmet need for prepayment of expensive laboratory and diagnostic services for ambulatory patients.—**Lowell T. Coggeshall, M.D.,** Special Assistant for Health and Medical Affairs to Secretary of Health, Education, and Welfare, Washington, D.C.

Below: Talking together after the federal hospitals luncheon were (l. to r.): W. V. Charter, director of statistical division, Bureau of Medicine and Surgery, USN, Washington, D.C.; Robert M. Tennille, Jr., and Herman E. Hoche, both instructors, Naval School of Hospital Administration, Bethesda, Md.; Willard Calkins, chief, Medical Service Corps, VA Bureau of Medicine and Surgery, Washington, D.C.; and Robert Jetland, administrative assistant to chief of Army Medical Service Corps, Office of Surgeon General, Washington, D.C.

Sane Person Has Right To Sound Crazy Sometimes

Mental Problems Are Emphasized
By Overevaluation of Symptoms

A person should be allowed to be afraid sometimes, to be occasionally forgetful, to be confused, to be a little compulsive, to have a little disturbed sleep, and even to be suspicious of someone without being labeled a mental patient.

He may employ every one of the mechanisms of defense, such as projection, displacement, forgetting, rationalization, and fantasy; he may be fearful and anxious on occasion and yet be a mentally healthy person, over-all.

These symptoms are as natural as getting out of breath after climbing a hill, becoming fatigued by exertion or having a sore muscle from unwanted exercise, or losing appetite when excited.

Some of the great problems of mental disorders are caused by an overevaluation of symptoms and failure to recognize them when they are in mild and occasional form. Such overevaluation creates confusions, exaggerates the already serious shortages in psychiatric and related manpower, robs people of personal responsibility, creates overdependence on specialists, and in general is crippling to society.

Preventive and early treatment services need to be emphasized. These services, which may be provided in part by local and state tax money and by private groups and individuals, include:

(1) Special education for handicapped groups; (2) public health nursing services; (3) well-baby and other

growth and development services; (4) counseling in schools and churches; (5) marriage and family counseling; (6) homemaking and other welfare services; (7) preparations for the particular stresses experienced in adolescence, in old age, at the death of loved ones, etc. and (8) recreational facilities.

Environment must be carefully studied. Successful rehabilitation of physical ills is playing a strong part in preventing additional mental breakdown. Economic assistance, job recovery, and help in personal disaster prevent the overstress of adjustment. Early treatment in advanced cases is remarkably effective.

Two factors are foremost in effecting rapid changes in providing mental care. One is the broadening of the concept of hospitalization for mental patients. Disorders are being treated successfully in subsidiaries of the parent hospital under careful supervision and with hospital facilities nearby.

The second great change, and one contributing equally

Above: Two nurse anesthetists who compared notes after the Federal Hospitals luncheon were Lt. Eunice M. Candee, U.S. Navy Hospital, Quantico, Va., and Capt. Cora E. Conerly, 6550th U.S.A.F. Hospital, Patrick Air Force Base, Fla.

to future hope, is the fact that progress in medicine has made it possible for mental disorders to be recognized earlier and thus often treated in the home, outpatient clinics, psychiatrists' offices, and community services.—**Daniel Blain, M.D.,** Medical Director, American Psychiatric Association, Washington, D. C.

Day of "Letterhead Trustee" Passing; Takes More Interest

Fewer and Better Board Members Considered to be Primary Need

The day of the "letterhead trustee" is passing.

Many leaders feel that fewer and better trustees is the primary need. The men and women asked to serve on hospital boards not only should be recognized and active community leaders but should indicate some knowledge of, or interest in, community health.

There is more and more trustee education, designed to provide the basic knowledge of health matters the trustee needs in order to fulfill his new role.

In successful corporate enterprises, in which so many trustees serve as officers and directors, duties are always well defined. They are executed with confidence and assurance. Knowledge and experience and the ability to plan intelligently are key ingredients in their important service to these enterprises.

But in hospital affairs trustees have not always known precisely what is expected of them. All too often we sense confusion and a hesitancy to assume leadership. The modern hospital trustee should contribute his service with the full knowledge that he must become intimately acquainted with the facts, figures, and trends in the hospital field.

He can then sharpen his decisive role in aiding the development of hospital services.—**J. Stewart Baker,** President, Chase Manhattan Bank, New York City.

Finds Fifth of New York City's Patients Have Nowhere to Go

Survey Reveals Facilities Needed To Relieve Hospitals of Chronic Cases

A recent survey of New York City municipal hospitals indicated that 19.2 percent of the patients no longer required hospital care but could not be discharged because of lack of other facilities.

Most of these patients were elderly individuals suffering from chronic diseases, principally cardiac, neurological and arthritic. Many of them will never recover sufficiently to return home, and the majority who can, will be at least partially incapacitated.

The long-term patient needs a modern hospital with the comfort and warmth of home — with small four to six-bed rooms which have ample seating facilities. Curtains and upholsteries should be colorful. Space should be provided for wheel chairs within easy reach of the patient without giving the room a cluttered appearance.

Bedside radios should have earphones. Sitting-rooms with simple draperies, small groups of comfortable chairs and tables, a few pictures, and some flowers could greatly help patients to maintain their emotional balance.

Separate rooms should be set aside for television, radio, and other recreational activities. A centrally located store in which patients can obtain small luxuries and necessities not provided by the hospital will substantially aid their morale.

These special facilities could be staffed, under the supervision of a few registered nurses, with carefully selected and specially trained practical nurses, voluntarily enlisted from the ranks of emotionally stable middle-aged women. The recreational facilities would have to be geared to the needs of the severely handicapped and partly or totally inactive patients.—**Howard A. Rusk, M.D.,** Chairman, Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City.

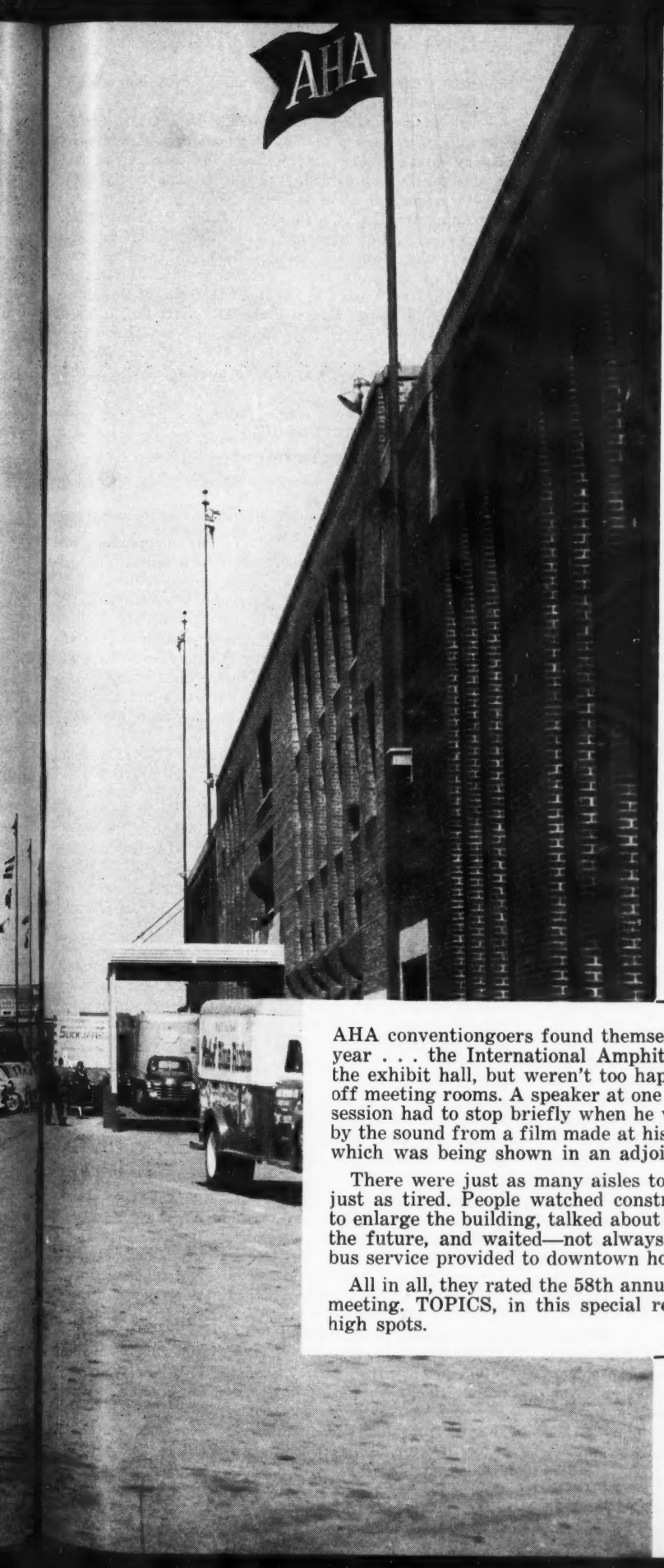
General Psychiatric Hospitals, Need Integrated Services

Outpatient Facilities Important

If a general hospital does not have a psychiatric unit, it is exceedingly difficult for it to cooperate with a specialized psychiatric hospital. The general hospital without a psychiatric unit usually does not have the required specially trained nurses and social workers — nor the

(Continued on page 24)

Col. Francis P. Kintz, surgeon for the Second Army area, Ft. Meade, Maryland, and Maj. Gen. J. M. Willis, M.D., U.S. Army (ret.), now director, Hamot Hospital, Erie, Pa.



AHA conventiongoers found themselves in a new spot this year . . . the International Amphitheatre. They liked the exhibit hall, but weren't too happy with the curtained-off meeting rooms. A speaker at one round-table session had to stop briefly when he was drowned out by the sound from a film made at his own hospital . . . which was being shown in an adjoining "room."

There were just as many aisles to tramp, and feet got just as tired. People watched construction work going on to enlarge the building, talked about their own plans for the future, and waited—not always patiently—for the bus service provided to downtown hotels by the AHA.

All in all, they rated the 58th annual convention a good meeting. TOPICS, in this special report, reviews the high spots.

over-all awareness of psychiatric problems. Cooperative or integrated services permit comprehensive evaluation of the psychiatric patient at a lower cost.

The importance of outpatient psychiatric facilities can not be overemphasized. Approximately 30 percent of patients now receiving outpatient psychiatric care would have been hospitalized 10 years ago. The value of short-term, early treatment and diagnosis is demonstrated by the fact that one 60-bed psychiatric unit of a general hospital in Rochester, New York, admitted more new patients in a year than a nearby 4,000 bed, long-term psychiatric hospital.

Whether or not a special psychiatric unit exists or is planned in a general hospital, the administrator should be familiar with the mental hygiene laws of the state.

The patient cannot be confined or retained in a hospital against his will without a court order. Most psychiatric patients in general hospitals are admitted voluntarily. Upon admission, the psychiatric patient usually agrees to be discharged only on a three-day written notice. The assumption is that during this period a psychiatrist can persuade the patient to remain in the hospital during this period.—**Lee G. Sewall, M.D.**, Manager, Veterans Administration Hospital, Pittsburgh; **J. Milo Anderson,** Administrator, Strong Memorial Hospital, Rochester, N. Y.; **Kathleen Black,** Director, Mental Health and Psychiatric Nursing Advisory Service, National League for Nursing, New York City; **August H. Groeschel, M.D.,** Associate Director, New York Hospital, New York City; **Helen McGregor,** Chief Psychiatric Social Worker, Michael Reese Hospital, Chicago.

Hotel Service Called Essential For Ambulatory Patients of Future

Might Reduce Costs,
Relieve Nursing Shortage

The hospital of the future will have to provide hotel service for the ambulatory patient as well as facilities for emergency and acute cases in order to keep costs within bounds.

Costly hospital facilities and services provided for the acute patient are being wasted on ambulatory convalescent patients and those admitted for diagnostic purposes. Two types of care can be provided—for the very sick and for the almost well. A hotel type of service for the ambulatory person, with meals on an American or European plan, not only would reduce hospital costs but would be beneficial to the patient's morale.

A drive-in, motel setup might be used for hospitals with available ground. Many voluntary institutions which draw from a wide rural area are located in communities which have poor hotel facilities.

A greater use of private and semiprivate patients in nonprofit hospitals will have to be made if these institutions are to draw interns and residents. This already is taking place in many areas. An obstacle in some sections is the objection of Blue Cross to paying for the care of such patients.

Municipal and county hospitals, which now limit their admissions almost entirely to charity cases, will in time be called upon to accept pay patients in separate divisions in order to maintain bed occupancy.

A segregation of hospital services into departments for the acute and for the ambulatory would reduce the nursing requirements and might ease the nursing problem.

Establishment of offices in hospitals for use of physicians in private cases will bring the patient closer to diagnostic facilities, save him time, and improve his mental outlook. Specialization has tended to "fragment" the patient. There is a growing demand for an understanding, personal physician.

Terms in medical care plans should be better defined, especially with regard to diagnostic admissions and pre-existing diseases. Also, there should be more education on the coverage provided. The patient has a right to know why an operation is being performed and to receive an explanation of his billing.—**Julian P. Price, M.D.,** Florence, S.C., Commissioner, Joint Commission on Accreditation of Hospitals; **George Baehr, M.D.,** President and Medical Director, Health Insurance Plan of Greater New York, New York City; **William C. Beck, M.D.,** Guthrie Clinic and Robert Packer Hospital, Sayre, Pa.; **Gilbert Cant,** Medicine Editor, **Time Magazine,** New York City; **Frederick D. Mott, M.D.,** Medical Administrator, Miners Memorial Hospital Association, Washington, D.C.

Pay Patients Increasing In Outpatient Department

Better Service Needed,
Possible Medical Care Coverage

The outpatient department will be the mainstream of future hospital care. But there must be a radical change in the concept of the program, because pay patients are supplanting indigents. OPD coverage by medical care plans is being considered, but it is controversial.

The evolution will not occur with the same degree of speed in all parts of the country. Changes will have to be made with the cooperation of the medical staff.

The outpatient department will have to adapt itself to the trend toward pay ambulatory patient care, and perhaps handle some of the geriatrics problems.

Some changes which are occurring are: (1) realization that good business practice, good medical practice and good patient care cannot be separated; (2) awareness that the quality of the department staff must be improved and measure up to the quality of other divisions; (3) more attention to the organizational structure; (4) realization that auxiliary members cannot be used as cheap labor; (5) recognition of the patient as an individual rather than as a number; (6) freeing doctors and nurses from clerical chores.

Material is more of the chronic type and not suitable for ward services. Many doctors have previously looked upon the clinics as chores, but now there is a growing realization that there are many opportunities for young doctors to acquaint themselves with problems they will encounter in general practice.

Costs have risen tremendously, but income has gone up to a lesser degree. A deficit of about $3 per patient visit was reported. As a result, hospital administrators have not looked with kindness upon the OPD. However, this situation can be partially overcome by more attention to possible referrals to social agencies.

Some of the changes in administrative practices are: (1) paying more attention to educating patients about procedures to be undergone, reducing anxiety and providing "good bridge conversation"; (2) accumulation of sample drugs for administration to indigent patients; (3) reduction in information taken upon registration of a patient; (4) increase in public relations consciousness of administrators; (5) concept of the patient as a customer rather than as ward or education material.—**Robert R. Cadmus, M.D.,** Director, North Carolina Memorial Hospital, Chapel Hill; **James T. Howell, M.D.,** Assistant Director, Henry Ford Hospital, Detroit; **L. Russell Jordan,** Business Manager, Medical Outpatients Clinics, Duke Hospital, Durham, N. C., and **David Littauer, M.D.,** Executive Director, Jewish Hospital, St. Louis.

Improved Care, Comfort In Air-Conditioned Hospital

Effective Maintenance
Can Reduce Cost

There is an increasing preference for air-conditioned hospitals — not only for patient and personnel comfort, but also for improved care — particularly among the cardiacs, the allergic, and patients recovering from neurosurgery. Because of the tensions and double-gowning in operating rooms, the temperature preference, where studied, has been found to range from 65 to 70° F.

Studies are now being conducted by the Public Health Service to determine whether or not it is safe to recirculate all or part of the air in the operating room, as well as in other areas in which recirculation is not now recommended.

Much of the cost of air-conditioning maintenance can be reduced by effective preventive maintenance. Air-conditioning manufacturers provide manuals which should be adapted to the detailed system installed in each hospital, and should show all filter installations and other points requiring periodic maintenance. A check-list should be prepared and effectively used for each installation.

There is an increasing use of the high-velocity double-duct system, which uses standard-size pipes for transporting the air, rather than the large ducts which usually increase the cubic footage of the hospital.

The high velocity system, which does not require added ceiling heights, can be used effectively to air-condition existing hospitals. If limited areas are to be air-conditioned, portable units may be found satisfactory. Usually, if a number of such units are to be installed, a separate, additional wiring may be required. It may be found that the cost of the portable units and additional wiring will approximate the cost of a comprehensive system. —**C. R. Youngquist,** Administrator, Sharon (Pa.) General Hospital; **Richard P. Gaulin,** Mechanical Engineer, Division of Hospital and Medical Facilities, Department of Health, Education, and Welfare, Washington, D. C., **John A. Holbrook,** Administrative Engineer, Presbyterian-St. Luke's Hospital, Chicago; **Donald L. Snow,** Chief, Sanitary Engineering Branch, National Institute of Health, Bethesda, Md.; **Joe Taylor,** Administrator, Orange (Tex.) Memorial Hospital.

Administrator Responsible For Good Hospital Planning

Must See Building Meets
Specific Needs of Personnel

The first step in a good hospital planning program should be a written identification by the administrator of methods and technics of operations, persons assigned, and equipment used in each area. This information should be translated to plans by the architect. The consultant ordinarily assists the administrator in developing the narrative program and the architect in translating the narrative to a functionally integrated facility.

The primary objective of the building is to be a skin over the hospital's functional and administrative activities. Too often the building is constructed and technics and administration are forced to adjust to the facility — instead of the building being built to the specific needs and requirements of the hospital and each activity therein.

The architect and the consultant must work closely together. There is a contrary opinion that a consultant should be employed first and be primarily responsible for the preparation of the program and the architect employed later to translate the program to plans and specifications.

Above: On their way to congratulate new AHA president Albert W. Snoke at the annual banquet were Bryce Twitty (l.), administrator, Hillcrest Medical Center, Tulsa, Okla., and Mr. and Mrs. Albert G. Hahn, executive director and associate executive director, respectively, Tri-State Hospital Assembly.

Below: Samuel Cardinal Stritch (r.), archbishop of Chicago, spoke at the Catholic Sisters luncheon. At left: the Rev. Frank Prentzel, Jr., D.D., president, American Protestant Hospital Association, Philadelphia, and Albert W. Snoke, M.D., new AHA president.

All key personnel should have an opportunity to evaluate the plans and to make comments in the schematic stage. A program should take into consideration future expansion and possible changes in utilization of the hospital.—**David B. Wilson, M.D.,** Director, University Hospital, Jackson, Miss.; **Paul A. Lembcke, M.D.,** Associate Professor of Hospital Administration, John Hopkins University, Baltimore, Md.; **Aaron N. Kiff,** Chairman, AIA Committee on Hospitals and Health, New York, and **E. Todd Wheeler,** Architect and Hospital Consultant, Wilmette, Ill.

Hospitals Need Master Plan For Long-Range Development

Must be Changed Periodically

Every hospital should have a long-range master plan. The responsibility for establishing policy and principles for such a plan rests with the board of trustees. A hospital should have a standing committee of the board for planning and development.

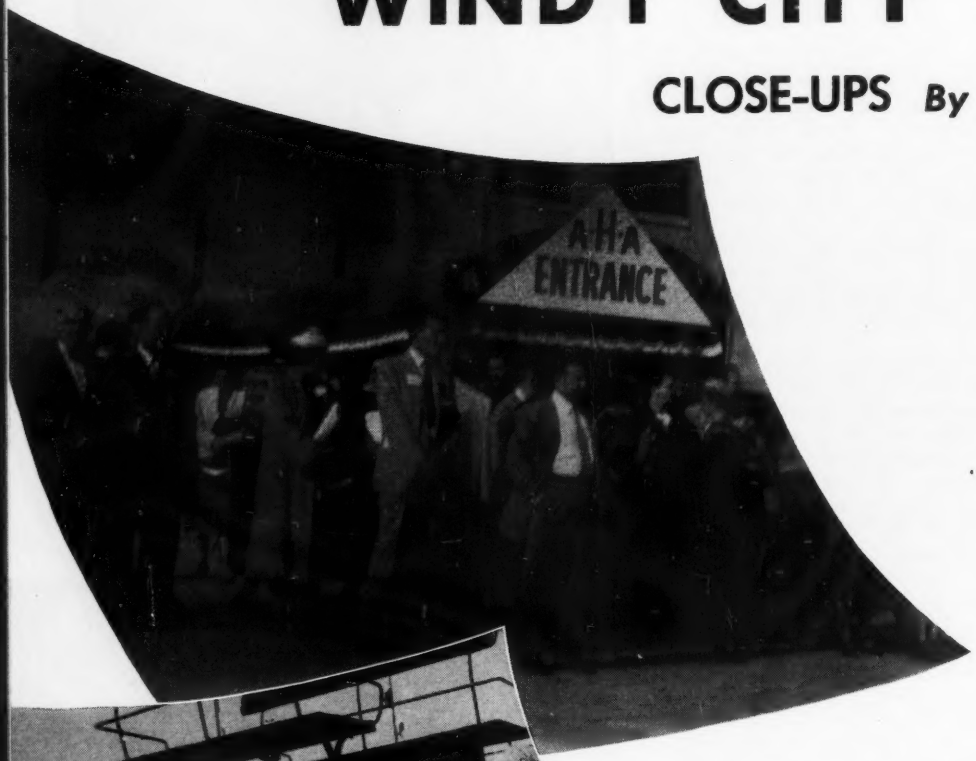
An effective master plan is not an inflexible product, but one which must be periodically re-evaluated in terms of changing conditions. This evaluation should include the services required in the community compared with those available in the hospitals serving the community. In developing a master plan for a given hospital, it often may be necessary to consider all the hospitals providing care in the service area.

To provide comprehensive services for all elements of

(Continued on page 28)

WINDY CITY

CLOSE-UPS *By TOPICS*



Above: The "5 o'clock rush"—conventiongoers wait for special buses to take them downtown.

Above: Pausing in front of picturesque vehicle outside Stock Yard Inn were directors of four Shriners' Hospitals for Crippled Children (l. to r.): Anne G. Williams, Salt Lake City; Margaret H. Rose, Los Angeles; Dorothy Andrew, Portland, Ore., and Marguerite J. Peck, San Francisco.

At right: These administrators, examining construction in progress at Amphitheatre, have been doing their own "planning for the future." At left is Denis De Manche, Naples (Fla.) Community Hospital, open six months; Harold Applin, assistant, St. Joseph's Hospital, Minot, N.D., is working on plans to enlarge 130-bed hospital to 225 beds. Bob Byrne, Providence Memorial Hospital, El Paso, is remodeling one patient area and adding a cobalt room.

At left: Administrator Naomi Bitz, R.N., Dobbs Ferry (N.Y.) Hospital, gratefully accepts offer to put her tired feet up on foot and leg rest at convention booth. Evelyn C. Enge (l.), Little Otto Co., makes her comfortable.

At right: HOSPITAL TRENDS, by Louis Block, published by HOSPITAL TOPICS at convention time, is examined by Mel Scheflin (l.), executive secretary, Association of Western Hospitals, San Francisco; Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif., and L. S. Sanders, Orthopaedic Hospital, Los Angeles.

At left: Charles F. Wilinsky, M.D., Boston, acknowledges standing tribute paid him after he received AHA distinguished service award.

At right: Sister M. Philomena, administrator, and Sister M. Canice, O.B. supervisor, Holy Name Hospital, Teaneck, N.J., discuss the $3,000,000, 115-bed wing their hospital has just completed in its "planning for the future" program.

the community, all the principal elements of the community must be represented on the board and have a means for making suggestions to the development committee.—**James A. Hamilton,** Professor and Director, Course in Hospital Administration, University of Minnesota, Minneapolis; **John P. Bent,** President, Presbyterian-St. Luke's Hospital, Chicago; **Edison Dick,** President, Board of Trustees, Passavant Memorial Hospital, Chicago; **John T. Ryan, Jr.,** President, Board of Trustees, Pittsburgh Hospital.

Joint Commission Approves Qualified Nurse Anesthetists

Proper Supervision Required

A hospital will not be criticized by the Joint Commission on Accreditation of Hospitals for the use of nurse anesthetists if the nurse anesthetist is qualified and is under the supervision of a surgeon or an obstetrician at all times.

Legally, administration of anesthesia is a medical act that can be performed by a nurse only under the supervision of a physician. In the larger hospital, supervision is generally provided by the anesthesiologist, but in a small hospital which does not have an anesthesiologist, supervision is provided by the surgeon or obstetrician.

This supervision must be actual and direct. For example, a nurse may not receive telephone instructions from the obstetrician so that the patient will receive anesthesia while he is driving to the hospital.

Small hospitals must continue to rely to a great extent on the nurse anesthetist. She should, however, be limited to areas of her competence. Her greatest failure is the tendency to overextend herself.

The surgeon should discuss with the anesthetist the anesthesia and the technic which he is to use. He should provide adequate time for induction.

When the anesthetists are permitted to practice in a number of hospitals, wider coverage for smaller hospitals results.

Active recruitment should be continued for both anesthetists and anesthesiologists. Governing boards should be acquainted with the problem of providing 24-hour anesthesia coverage and the problems inherent to the legal responsibilities in the induction of anesthesia to patients. Small hospitals should consider joint action so that one anesthetist can give wider coverage, and should support training programs for both anesthetists and anesthesiologists.—**A. C. Kerlikowske, M.D.,** Director, University Hospital, Ann Arbor, Mich.; **John Adriani, M.D.,** Director, Department of Anesthesia, Charity Hospital of Louisiana, New Orleans; **J. Garrott Allen, M.D.,** Associate Professor of Surgery, University of Chicago; **Minnie V. Haas, R.N.,** President, American Association of Nurse Anesthetists, Fort Worth, Texas, and **Emanuel Hayt,** Counsel, Hospital Association of New York State, New York City.

Vice-Admiral Joel T. Boone (l.), Medical Corps, USN (ret.), and R. E. Adkins, executive officer, VA Bureau of Medicine and Surgery, Washington, D.C., who presented citation to Admiral Boone at federal hospitals luncheon.

Accreditation Problem Clinic

Two new items will be surveyed for accreditation hereafter:

(1) Plans for mass evacuation and reception of casualties. The plan should include effective communications during evacuation, and methods for identification of patients.

(2) Stop order on drugs. Medical staffs of hospitals should check unspecified orders at 48, 56 or 72-hour intervals,

Any hospital which has osteopathic physicians on the staff or permits them to use its facilities will not be surveyed. Within one to five years there will probably be some allowances made for osteopaths.—**Kenneth B. Babcock, M.D.,** Director, Joint Commission on Accreditation of Hospitals, Chicago.

Q. Must a hospital have a pathologist in direct charge of all lab procedures?
DR. BABCOCK: No. It is acceptable if at least once a month a pathologist visits and checks the technician and results of laboratory work.

Q. What is the practice in sending the survey report to a hospital?
DR. BABCOCK: Since a year ago last March, the procedure has been to send three copies — one to the chief of staff, one to the administrator, and one to the chairman of the board, with a covering letter suggesting that all three get together and then make any announcements they care to.

Q. Has the report been changed that must be supplied for the survey?
DR. BABCOCK: Forms are not copyrighted. Several companies have reproduced them. No substitute forms have been produced in the commission's name.

Q. We have a 72-hour stop order. If a doctor orders PRN and it is not given, does it automatically stop?
DR. BABCOCK: Yes. Whether it was given or not, it has expired. It was 72 hours from the time given, not the time started.

Q. Is it necessary to do microscopic examination on such tissues as hernia, cataracts, etc., which can be examined grossly?
DR. BABCOCK: No. But each tissue must be sent to the lab when it is removed in surgery. It should be described so that there is an accurate record. For example, in the case of teeth removal, it is important to specify whether or not all roots were out. The staff decides forms of tissue to be microscopically examined.

Q. Can isotope specialists, clinical psychologists, physicists, and chiropodists admit patients?
DR. BABCOCK: No. They are not on the same level as the physician or dentist. They are technicians and therefore cannot admit patients.

Q. Does the Joint Commission have specific rules with reference to outside drugs being brought into the hospital?
DR. BABCOCK: Yes. Hospital and nursing staff should know about them. If the doctor writes that drugs brought in will be given, the hospital must accept this decision.

Q. If a hospital's mass casualty plans have not been completed when the Joint Commission representative comes, would accreditation be refused?
DR. BABCOCK: Accreditation is generally not refused because of one item. The hospital would be criticized.

Historically Pediatric Units Have Gone Through Big Change

Now Idea Child Best Cared For Within Family is Prevalent

Historically pediatric units have changed in the last 25 years from large institutions, to smaller institutions, to units in the general hospital, to the idea that the child can be best cared for within the family unit.

When we hospitalize the child, we are subjecting him to more emotional trauma than he would otherwise have. When possible oral therapy should be given instead of parenteral therapy.

If a general hospital can't care adequately for the child he should be transferred to a specialty hospital.

In 1954 the Academy of Pediatrics recommended that:

1. Pediatrics should be recognized as one of the four basic divisions of the hospital.
2. A pediatric service should have roughly 10 percent of the hospital beds.
3. Each pediatric unit should have at least one board-qualified pediatrician.
4. Small units of 12-15 beds are needed for an intern for his term of duty.
5. Nurses and aides need pediatric orientation.

A comprehensive pediatric unit may be like a small hospital with many special units — for example, a laboratory with a technician trained in micro technics, or an x-ray unit with a technician trained in reassuring children.

A hospital can request a special teacher in some states through the department of special education. In Wisconsin the state department of special education reimburses the hospital for a special teacher's salary.

School can be set up in wards, corridors, or in sun parlors.

New methods, such as group work, movies, and television are now used as teaching aids.—**Mrs. Margaret Van Wie,** School Teacher, Milwaukee (Wis.) Children's Hospital; **Mila Pierce, M.D.,** Associate Professor of Pediatrics, Bob Roberts Memorial Hospital for Children, Chicago; **A. R. Shands, M.D.,** Medical Director, Alfred I. du Pont Institute of the Nemours Foundation, Wilmington, Del.

Predict Combined Medical Care, Public Health Service

Report Success in Denver, Philadelphia

Coordination of public health services and medical care is effective in localities in which it has been tried.

Biggest obstacle to the program is the long-established belief that the two functions should be separate entities. However, the public probably will force the issue.

One of the problems is educating doctors that this is not a step toward socialized medicine, but rather a movement for a more efficient and economical health setup. Public health officers also have shown resistance to an integrated program.

Philadelphia and Denver are examples of integrated health and hospital departments. In smaller communities, integration has been effected between the public health service and nonprofit hospitals. Usually each functions separately administratively, but the activities are combined under one roof.

Health councils with the right leadership can be effective in obtaining united community support in health care planning.—**R. C. Williams, M.D.,** Director, Division of Hospital Services, Georgia Department of Health, Atlanta; **Graham L. Davis,** Straits, N. C., Hospital Consultant; **Jacque B. Norman,** Greenville, S. C., Hospital Consultant.

Right: Leo Lyons, executive director, American Protestant Hospital Association, takes a moment from his busy activities to eat an ice-cream sandwich.

Small Hospital Needs Flexible Engineering Staff

Must Know Maintenance, Requisitioning of Materials

In large hospitals, the hospital engineering department may be divided into two major branches — utilities and maintenance. The maintenance branch may be further subdivided into the various trades, such as plumbing, painting and carpentry.

The small hospital, however, is dependent upon the flexible utilization of personnel. Thus the department cannot be subdivided. Often the engineers must assist the maintenance crew, whose members should have sufficient flexibility so that they can assist each other in their special trades.

The major problem of this department is the method of requisitioning and controlling job orders. The job order should be recorded and work should be assigned to the proper unit for performance. Time required for the performance of the requisitioned work and the materials used should be recorded for costing purposes. In hospitals which have effective budget systems and cost control, work should be charged to the requisitioning department.

A major deficiency in most hospitals is the lack of an effective preventive maintenance system. A check-list of all items which should be periodically checked should be prepared and carefully adhered to. In many instances, expensive, major repair jobs are necessary because of failure to oil, to change a gasket or a filter, or to make a minor adjustment. **Jay W. Collins,** Executive Director, Euclid-Glenville Hospital, Euclid, O.; **Arthur D. Barnes,** Superintendent, Plant Operation and Construction, Memorial Center for Cancer and Allied Diseases, New York City; **Everett W. Jones,** Vice-President, The Modern Hospital Publishing Co., Inc., Chicago; **Daniel M. Roop,** Administrative Engineer, Baptist Memorial Hospital, Memphis, Tenn.

(Continued on next page)

Above: F. G. Whelply, administrator, Wyandotte (Mich.) General Hospital, Mrs. Frances Valenti, auxiliary member, Fairview Park, Cleveland, and Jay Collins, administrator, Euclid-Glenville Hospital, Euclid, O., at reception for incoming president Snoke.

Left: Sister M. Theophane, administrator, St. Joseph Hospital, Lorain, O. accepts grand award in 1955 AHA safety contest from Albert W. Snoke, M.D., new AHA president. St. Joseph Hospital has gone three straight years without a loss-time accident.

AHA Continued

Safety Program of Hospital Is Year-Round Affair

Employees Oriented with Films, Surveys, Discussions

When we set out to design a safety program at St. Joseph Hospital to fit our needs, we knew we had to convince department heads that accidents can be controlled — that they are caused by unsafe acts and unsafe conditions. Defining the problem was the first step toward solving it. A group of key people met with the administrator to uncover the problems and find out attitudes of employees regarding frequency of accidents in the hospital.

This group recommended that safety be the theme for all inservice education programs. The film, "Diagnosis Danger," was used to alert employees of existing or potential hazards. Discussions followed the films.

Department heads, supervisors, and nurses were asked to survey their departments to:

1. Discover existing hazards.
2. Ascertain degree of "safety consciousness" and employee attitudes.
3. Determine employees' knowledge of location and use of fire extinguishers and their alertness in detecting fire hazards.
4. Obtain criticism and recommendations for improving the hospital security program.

The survey revealed that:

1. Employees lacked knowledge of location and use of fire-fighting equipment and fire exits.
2. There was carelessness in handling broken glass and dishes in the dietary department.
3. There were a number of unsafe electrical practices — overloading of electrical outlets, repairing extension cords with adhesive, using frayed electrical cords, and neglecting to replace burned-out bulbs.
4. There was careless handling of equipment.
5. Patients and visitors smoked freely throughout the hospital.
6. Sharp instruments were thrown in with soiled linens.

The number one problem has been and still is enforcing smoking regulations. Control of patient smoking is most difficult. Employees are indoctrinated to their responsibility for enforcing regulations.

Close cooperation between the housekeeping and the maintenance departments was established. Accident hazards in the hospital were emphasized in the orientation program for new employees. Attractive posters, bulletins and slogans were used. This educational program is continuous.—**Sister M. Theophane,** Administrator, St. Joseph Hospital, Lorain, O.

Spread of Infection Prevented by Elevation of Housekeeping Standards

Ultraviolet Effective If Intensity Focused on Particles to Kill

Elevation of standards in hospital housekeeping in the last 20 years has helped prevent the spread of infection. As a prevention to the spread of infection housekeeping standards must be reviewed. Personnel must be observed to see where the infections originate.

As a technic of control, hospital employees and staff members must be immunized. Also, mechanical factors must be considered. Avoidance of dry-dusting and shaking out of linens must be observed in good housekeeping procedures. An oil fabric coating will trap germs and reduce the general loading environment.

Ultraviolet irradiation is only effective if the intensity is focused on the particle to kill. Glycol vapors won't do the job unless they are carefully observed.

Phenol compounds spread on furniture can retain their germicidal activities for 40 days. In a recovery room suite survey, bacterial content was reduced by 90 percent when these compounds were used.

An influenza virus can survive 16 months in a dried state and retain its effectiveness. The rate of death is great as the humidity goes up. Streptococci have a long survival rate in environments of high altitude and low relative humidity.—**William Lester, Jr., M.D.,** Suburban Cook County Tuberculosis Sanitarium District, Hinsdale, Illinois.

Standardization of Rates Unlikely, But Might Agree on Formulae

Two Booklets Suggested As Rate-Setting Aids

There are so many rate arrangements and cost arrangements in hospitals that it is pathetic. It is very unlikely that we will ever have standardization of rates, but it is desirable to work toward more standardization of formulae used to arrive at rates.

More and more hospitals are making individual charges for ancillary services (getting away from inclusive rates), and are attempting to base their rates on costs.

The inclusive rate works well for the patient, but the Johns Hopkins Hospital lost close to $3 million in the two and one-half years the inclusive rate was used. Whether or not the patient will be happy with the inclusive rate depends upon the services he receives. A patient who is in for only a couple of days and receives a minimum number of services may rightly feel that he has been stuck — because he is paying for the very sick patient.

Hospitals themselves cannot agree on a method of developing costs and a charge schedule. Two booklets that have been issued to help hospitals establish rates are the new *Guide for Hospital Rate Setting*, published by the

Below: Special citations from the AHA were presented by Ray E. Brown (l.) to Sen. Lister Hill (r.), and Associate Justice Harold H. Burton of the U. S. Supreme Court, honoring them on the 10th anniversary of the Hill-Burton program.

Left: Emory W. Morris, D.D.S., president and general director, W. K. Kellogg Foundation, Battle Creek, Mich., receives an honorary AHA membership from Ray E. Brown at the annual banquet held at the Palmer House.

Honorary memberships are presented by Ray E. Brown to George F. Lull, M.D. (above), secretary and general manager, American Medical Association, Chicago; and Theodore G. Klumpp, M.D. (l.), chairman, Hoover Commission's Task Force on Medical Services, and president, Winthrop Laboratories, New York City.

AHA, and the booklet, *Establishment of Hospital Rates*, published by the Hospital Council of Greater New York in 1951.—**Lee S. Lanpher,** Administrator, Lutheran Hospital, Cleveland; **Harry O. Humbert,** Controller and Assistant Treasurer, The John Hopkins Hospital, Baltimore; **Susan S. Jenkins,** Executive Director, Kansas City Area Hospital Association, Kansas City, Mo.; **Herbert E. Klarman,** Associate Director, Hospital Council of Greater New York, New York City.

Question and Answer Period

Q. Is the inclusive rate better for public relations?

MR. LANPHER: In my opinion, it is. We use a modified inclusive rate. Some of the items it does not include are fees of private physician in medical consultation, x-ray examination and therapy, radium, blood and blood services, charges for transfusion, O.R. fees, unusual drugs and medications, and outpatient services.

Q. Isn't the trend away from all-inclusive rates?

MR. LANPHER: In Cleveland, which had all-inclusive rates about as much as any area, the trend does seem to be away from them.

Q. How often should you change rates for public acceptability? On what basis are you going to change rates?

MR. HUMBERT: You are not going to increase your rates because your census varies. You should at least cost out your service once a year to see where you are heading.

Q. What is the deciding factor for changing your rates?

MR. LANPHER: In my hospital, it's figures in the red!

Organization Determined By Individual Situation

Should Make Best Utilization Of Human Resources Available

The type of organization used in the hospital should be determined by the individual situation. The basic need is to use human resources to the best possible advantage. Since the human resources vary from hospital to hospital, it is foolish to say, for instance, that every 300-bed hospital should have a certain type of organization.

The administrator must feel his way, and get acquainted with the people on his staff. The first thing to determine, in seeing whether he needs one or more assistants, is whether he has delegated all the authority he can.

The volume and type of problems must be considered in deciding what type of organization should be chosen. Any organization chart set up must be subject to change.

Designating an assistant administrator as "administrator in charge of professional activities" (also called "coordinator of patient care" by a member of the audience) may be a wise move to correlate under one person all department activities relating to patient care.—**Donald W. Cordes,** Administrator, Iowa Methodist Hospital, Des Moines; **Robert W. Bachmeyer,** Director, St. Barnabas Hospital, Minneapolis; **David S. Ritner,** Superintendent, Organization Planning, United Air Lines, Chicago; **R. Z. Thomas, Jr.,** Administrator, Charlotte (N. C.) Memorial Hospital.

Financial Plan Needed Before Building Plans Are Begun

Public Will Give Provided Program Is Explained

A comprehensive financial plan is needed for each hospital before detailed planning of the facility is undertaken. A program must be developed and rough cost estimates made. Without such preliminary steps there is no "product" which can be sold to the community.

There has not been a decrease in the willingness of the general public to give, provided the program is understood and accepted. Capital funds provided by foundations and industry have increased substantially in recent years.

Besides the Hill-Burton program, there are a number of other government subsidies which should be investigated when the financial plan is being developed. Under title I of the federal housing act, a hospital may be able to obtain property cleared in slum clearance programs at a cost substantially below its true value.

In urban communities, hospitals have been able to obtain parking facilities through their parking commissions. In other instances hospitals have had driveways, special roadways, sewers, and other utilities, provided by the local government. A new hospital, or one which is planning for expansion, should work closely with a local planning commission if such an agency exist.

Hospitals have been generally considered poor loan risks by banks and other financial institutions. In the East, loan money is becoming particularly difficult to obtain. Some units of a hospital may be financed by borrowed funds more easily than other units — for example, doctors' offices in a medical center development can be financed by insurance company loans. In such instances the financial plan should anticipate borrowing money for a particular building instead of for the entire project.—**A. C. Kerlikowske, M.D.,** Director, University Hospital, Ann Arbor; **Lewis Finch,** Senior Vice-President, Will, Folsom and Smith, Inc., New York City;**Martha O'Malley, M.D.,** Director, Division of Hospital and Institutional Services, Indiana State Board of Health, Indianapolis;

(Continued on next page)

Richard S. O'Riley, President, R.S. O'Riley & Co., Chicago; **Delbert Ly. Pugh,** Executive director, The Columbus, (O.) Hospital Federation; **E. Benjamin Redfield, Jr.,** President, Lynn (Mass.) Hospital.

Union Welfare Funds Will Influence Blue Cross Contracts

Varied Reimbursement Policies Contribute to Confusion

Union welfare funds will have a substantial impact on the number of persons covered by Blue Cross and the type and kinds of contracts for Blue Cross rights. Plans will become increasingly tailored to the needs of union membership. There will be, in addition to a base contract, an increasing number of elective or side benefits.

While it may be ideal to have reimbursement based on the quality of care rendered, this is not possible, because there are no effective criteria for measuring quality of care. Consequently, when reimbursement is based on cost, the assumption is that cost is consistent with quality.

Lack of uniformity in reimbursement policies of various government agencies has contributed greatly to the confusion in the minds of the public and in hospital operations. For example, there is generally a lack of uniformity in the payment for categorical government welfare programs, such as old-age assistance, ADC, crippled children's programs, aid to the blind, and aid to the totally disabled.

The present high economy has not necessitated a need for improvement of medical indigent programs. However, at the local level, when accounts receivable rise suddenly and substantially, it may be an indication that there is a need to evaluate the local program for the medically indigent.—**Hiram Sibley,** Director of Program Development, Yale-New Haven Medical Center, New Haven, Conn.; **C. Rufus Rorem, Ph.D.,** Executive Director, Hospital Council of Philadelphia; **Charles G. Roswell, C.P.A.,** MacNicol, Roswell & Co., New York City; **Carl K. Schmidt, Jr.,** Superintendent, Cook County Institutions, Oak Forest, Ill.

Planners Discuss Hill-Burton, Research Projects, Nursing Homes

The eighth annual meeting of the American Association of Hospital Planning was held September 16 and 17. The following are abstracts of some of the papers presented on this group's program.

Suggests Possible Hospital FHA, Integrated with Hill-Burton

The Hill-Burton program has made great contributions in the broad field of legislation by establishing a pattern for cooperation between governmental and voluntary effort. I am concerned, however, about some of the small hospitals built in this program. Small hospitals are usually inefficient and expensive to operate.

There is a need for detailed studies to develop hospitals that are consistent with present-day needs. For example, 20 percent of the patients in hospitals do not need bedside care but simply require hosteling adjacent to the hospital.

There is a tremendous need for help in the construction of nursing schools. This year, for the first time, schools of nursing are unable to take all applicants. Each year seven percent of the high-school graduates go into nursing, and the number of high-school graduates will increase greatly in the next few years. Teachers will be needed for the increasing number of students who will seek nursing education.

Loans being made to proprietary hospitals through th Small Business Administration ignore the orderly cha of planning provided in the Hill-Burton program. Need construction is of elementary importance to hospital including schools of nursing. Many need additional fun other than those available in existing programs. It conceivable that there is a need for a hospital FHA pr gram which would be integrated with Hill-Burton.—**R E. Brown,** Immediate Past President, American Hospit Association, and Superintendent, University of Chica Clinics.

AHA Research Project Studies Planning, Licensing Laws

The study of hospital planning and licensing laws, bei sponsored by the AHA with funds provided under the r search grants program of the Public Health Service, h as its objectives:

(1) To analyze the provisions of state hospital licensi laws and all administrative procedures of the agenci responsible for administration of these laws.

(2) To determine the relationship of state licensi laws and administrative agencies with other laws a programs within each state.

(3) To develop criteria for determining the types a kinds of laws and staffing required for extensive hospit licensure.

(4) To establish recommended administrative proc dures which would emphasize educational elements in ho pital licensure.—**Hilary G. Fry,** Project Director, Ho pital Planning and Licensing Law Study, American Ho pital Association, Chicago.

Study Seeks Agreement On Hospital Terminology

One objective of the research project on future nee for hospital facilities is to establish satisfactory termin ogy in the hospital field. The lack of agreement is severe handicap.

For example, how many hospitals agree on what ser ices should be included in "basic room charge?" Is patient chronically ill if he is hospitalized for 30 da or 60 days, or 90 days, or if he has one or more of series of prescribed conditions?

What does "convalescence" mean? Some may answe "Convalescence is the period between a patient's acu illness and his return to his previous state of health But may he not be in a better state of health? We ha found 11 interpretations in our study of the subje

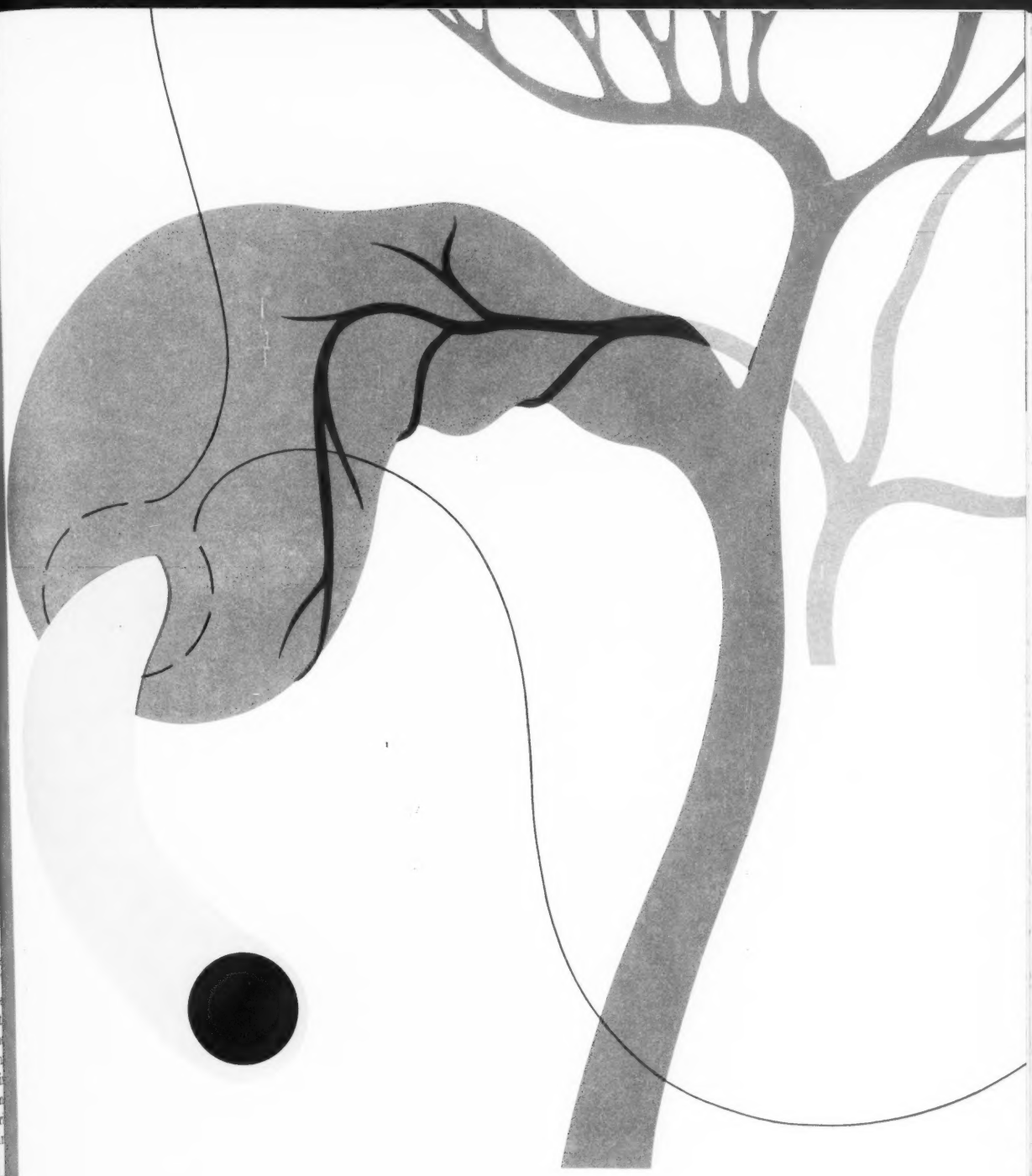
There are 62 different definitions of "hospitals." O expert describes a particular type of institution in ter of services; another in terms of facilities; a third terms of type of patient being treated; a fourth in ter of aberrant physical or mental conditions. A fifth author ty will say we must define our hospitals and related i stitutions in terms of functions and standards.

We will attempt to clarify some of these definition —**Alan E. Treloar, Ph.D.,** Director of Research, Ame can Hospital Association, Chicago.

Important Elements Ignored In Planning Nursing Homes

Many important elements have been de-emphasized ignored by planners of nursing homes. In the licensi program for nursing homes there is need for a classifi system which would take into consideration the size a type of operations being supervised.

Nursing homes must be planned for the needs of t aged, because they primarily serve the older populati group. They should be built in units of 30 for econo cal operation.—**Bert Cohn,** Owner and Operator, Washi ton Springs Nursing Homes, Okawville and Benton, I



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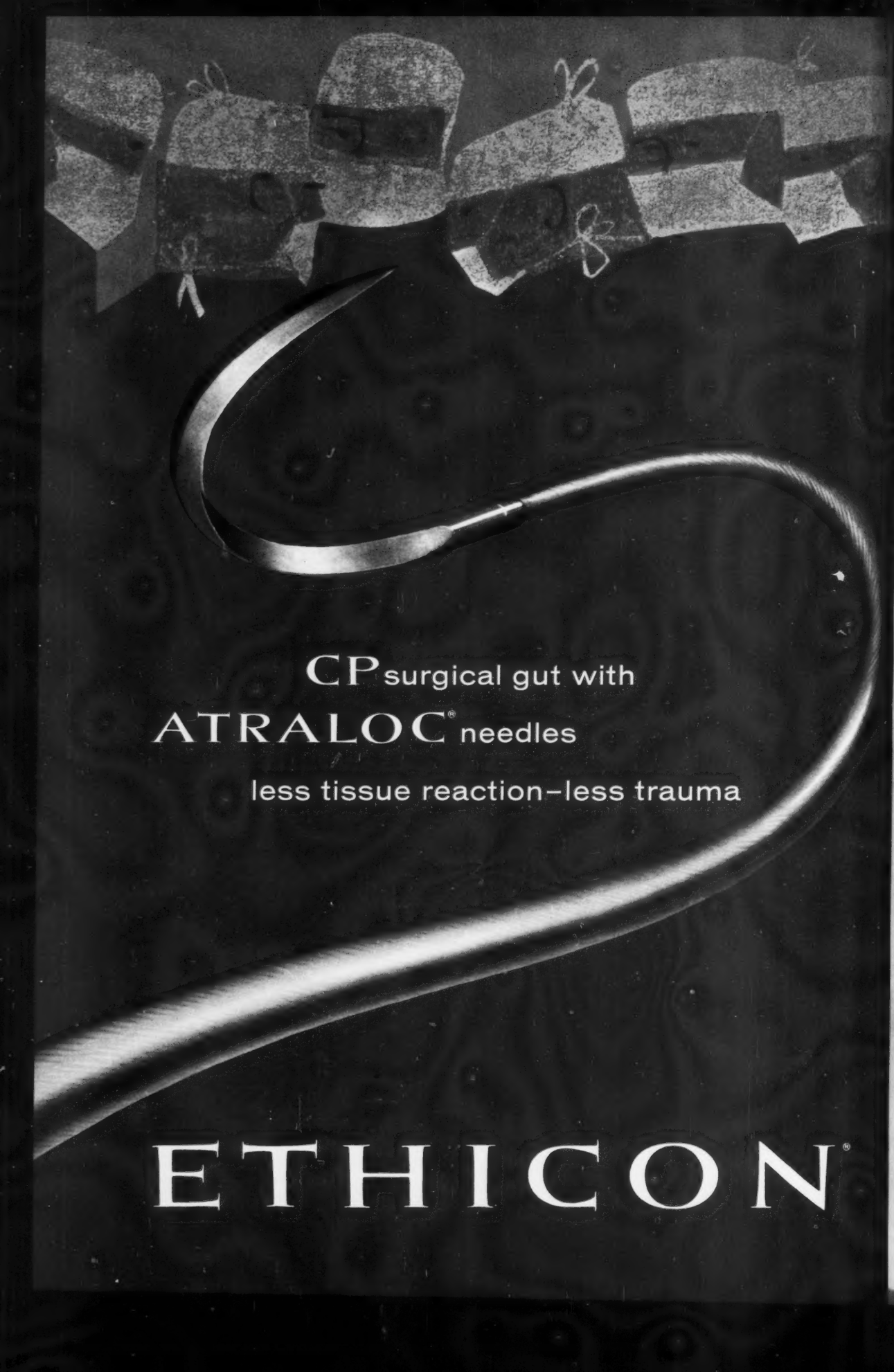
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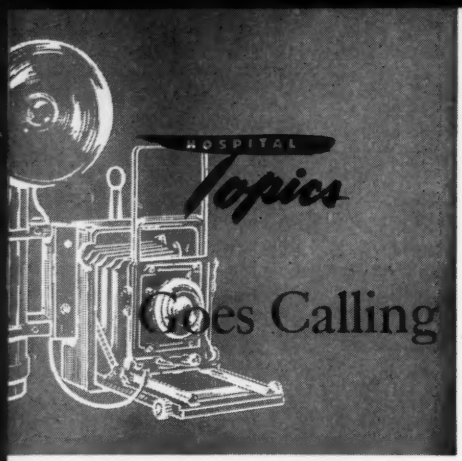


. . on Roy Patton

Administrator

Crossroads Rehabilitation Center

Indianapolis, Indiana

● On a twelve-acre woodsy tract overlooking Fall Creek in Indianapolis is Crossroads — a beautiful new rehabilitation institute finished in pink Haiti brick. This center has the most complete rehabilitation program of any center in the nation.

In its 19,200 square feet it can train and teach 2,500 physically handicapped persons a year.

The structure was built under the direction of the Marion County chapter of the National Society for Crippled Children and Adults with complete cooperation of the Indianapolis Medical Society. No federal or state funds went into the $300,000 structure.

Groundwork for Crossroads Rehabilitation Center was formed by the Indiana Rehabilitation League. The name Crossroads was chosen by Mrs. P. R. Mallory in 1942. In 1943 the first unit under the name of the Marion County Society for the Crippled was organized.

Roy Patton, present executive director of the Center arrived at Crossroads in 1950 from the Oklahoma Rehabilitation Division.

"Crossroads does not include just occupational and physical therapy rehabilitation," according to Roy Patton. "An entire team concept is used at the Center. It includes the four aspects of medical, social, psychological, and vocational rehabilitation. The recreational and nursery program are an extension of the basic four."

Above: Margaret Smith, OTR, shows James Burchan the best way to get in and out of the bathtub by himself. Also in the Activities of Daily Living Room are showers, toilets and beds. Nothing in the room has been specially constructed. It is similar to what they have in their own home.

A complete rehabilitation service is rendered at Crossroads from the time the patient is discharged from the hospital until he is placed in productive employment. Each patient must be referred through a physician. In a five-year period 400 physicians referred patients to Crossroads. Now eight or nine new physicians refer patients each month.

COMPLETE CURATIVE WORKSHOP

Crossroads has a curative workshop — the idea for it is five years old. The idea of the workshop according to Daniel Osborn, workshop director, "is to try to make people self-sufficient, to be able to get out on their own and get a job. People shouldn't stay permanently in a sheltered workshop situation."

Workers in the workshop are paid on a piece rate instead of an hourly rate. There are no pressures except what they put on themselves — their own ambition and desire.

Over $40,000 worth of business machines, power tools and sewing machines are used throughout the year in the workshop.

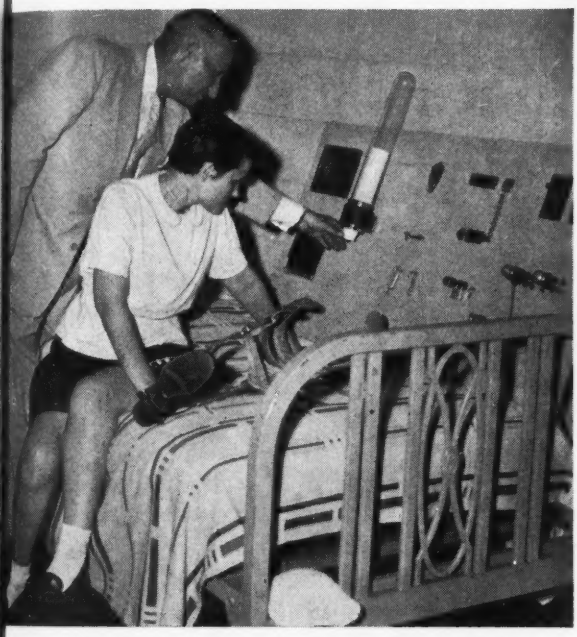
Last year 107 persons were returned to productive employment from the Center.

An Activities of Daily Living Room has all the equipment necessary for individuals to learn to care for themselves. For some individuals the process of getting from a wheelchair to a bed might be just as good a rehabilitation as the individual that eventually leaves the Center to full time employment.

In the vocational rehabilitation division psychological testing is carried on. The capacity, aptitude and learning ability of the handicapped individuals are tested. Also school readiness and the grade level of children. Suitable vocations for adults are determined.

Below: Only those who need to be carried are brought to the Center by station wagon. The Center has three cars at its disposal. During the school season about 20 children are transported daily to the nursery. About one-third of the people employed in the workshop are transported.

Right: Roy E. Patton, executive director, Crossroads Rehabilitation Center takes a call. The custom-made furniture in his office was donated by an Indiana firm. His desk is solid oak, the sofa is beige, the chairs are rust colored, and the walls are a soft turquoise. A local interior decorator donated her services in planning the interiors of the reception, conference, waiting room and Mr. Patton's office.



In the Activities of Daily Living Room, Mr. Patton points out some commonly used items to Mrs. Betty Schmalz. She can practice all the things she would normally do in her own home, like opening a faucet, closing a door latch, pulling down a paper cup, or plugging in a light cord.

Mrs. Patton, as social service director, evaluates the physical, emotional and economic factors of the patients. She integrates the services of the Center through her weekly case conferences.

Crossroads takes nursery school children — ages two and one-half to five, with the prerequisite that the mother must observe for at least one-half day per month. The Center tries to keep the parents from feeling that their child is a poor little crippled child — rather the child is working toward becoming a self-reliant individual.

The vocational and adjustment training shop teaches skills to be used for gainful employment in typing, bookkeeping and the machine shop.

Later in the year the kitchen will be opened. There patients will be re-educated in domestic skills.

STAFF CONSISTS OF 27

The staff consists of 27 full-time workers and two part-time workers. There are four physical therapists, four occupational therapists, a nursery teacher, a workshop director, a medical director, a social worker, a vocational director, two drivers, a custodian, three secretaries, a bookkeeper, an executive director, two ward aids in physical therapy, four workshop assistants, and a worker in vocational training and blind adjustment. There is a psychologist and a public relations person on part-time basis. Crossroads wants to add a group worker, a physical therapist and an occupational therapist in the fall.

Treatment at Crossroads can be paid for in one of three ways. If an individual is able he pays the entire fee. There is an adjusted fee for those who can't pay the entire amount. The Center does not like to go down lower than $1 on those individuals. Some patients don't have to pay anything — the Polio Foundation, Crippled Childrens Society and Vocational Rehabilitation pays for some of those patients.

A camp near Troy, Indiana, called Koch Camp is run in conjunction with Crossroads. The camp is situated on a bluff overlooking the Ohio River. Forty children come for two-week sessions. There are 14 staff members.

Crossroads runs a day camp during the summer where 40 children attend. This camp is solid recreation — camping without actually going to a camp. Children don't make small articles anymore because a girl asked the executive director, "Why can't we just play? Why do we always have to be making things like we did when we were in the hospital?" So Crossroads changed its original day camp program.

Evening activities are scheduled at Crossroads every night of the week except Thursday which is open time. Monday it is Boy Scouts, Tuesday Camp Fire Girls, Wednesday the Adult Rehabilitation League, and Friday a teen-age group.

The teen-age group is called "Happy Hobos and Sad Sacks." Their activity is as varied as their handicap is — from mild entertainment such as cards up to the more vigorous types such as dancing.

AFFILIATIONS OF CENTER

Crossroads has an affiliation with Butler University. Special education students practice teach at the Center. In turn Butler does the psychological testing on adults at the Center.

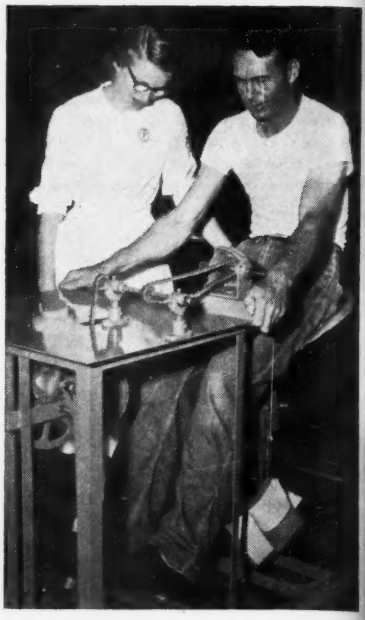
The New York Institute for Crippled and Disabled sends their student directors to the Center for seven weeks. The Center uses them as staff during their stay.

Now Crossroads is in the process of working out a relationship with Indiana University School of Social work and group recreation.

Nursing homes in the area work with Crossroads for the rehabilitation of severely handicapped people. The geriatric patients are transported to the Center and are integrated in the shop and recreation program.

(Continued on next page)

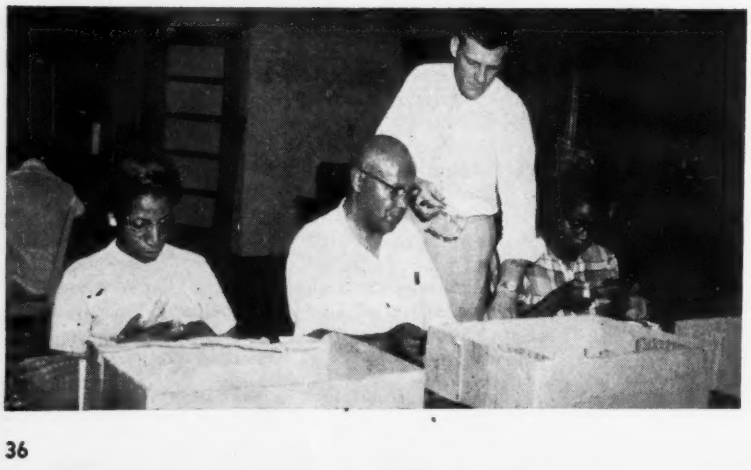
Above: Lawrence Grey carries Mrs. Betty Schmalz out of the Center's station wagon and places her in the wheelchair so she can wheel herself into the building. There are no steps in the structure — doors open electromatically, and are extra wide to allow for wheelchairs. A self-service elevator ramp leads to the basement from the outside.



Right: Mrs. James W. Conine, OTR, helps Leonard Parker on the sander machine, which is used as a strengthening exercise for legs. As weights are added, Mr. Parker is forced to pump harder.

Above: Mrs. Betty Bainbridge, speech therapist, has developed a special board for blowing ping pong balls, designed to aid cleft-palate patients in developing better breath control. Mrs. Donna Jophlin, using a straw, tries to blow the ball into the hole on the far side of the board.

Above: Beth Bagley, R.P.T., gives Bill Senders exercise in the new $5,200 Hubbard tank. The entire body can be submerged into the whirlpool bath to increase circulation and stimulate nerve ends. Seventeen year old Mr. Senders comes to the Center three times a week for his post-polio exercise.

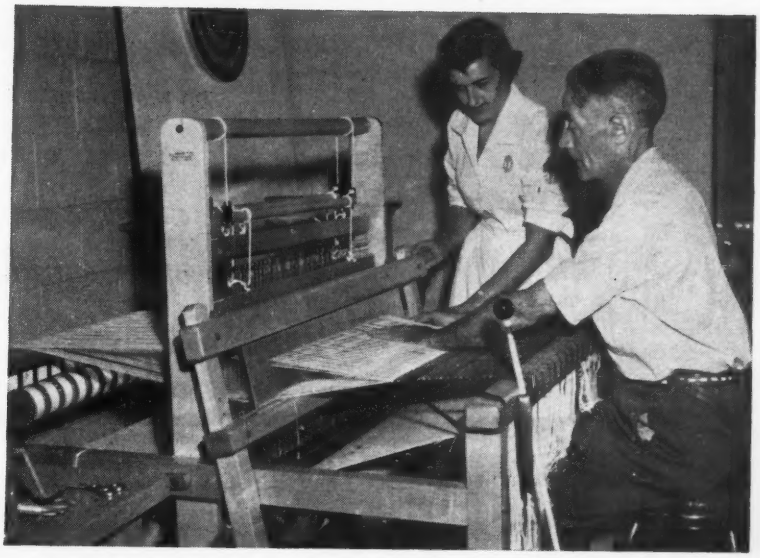


Left: Daniel Osborn (standing), director, Curative Workshop, helps Ruth Anthony, Clifford Hord, and Wilma Johnson with their project of trimming the excess "flash" from coin containers. The group in the workshop are doing a job for Western Electric, and are paid on piece-rate basis.

Above: Myron Martin comes to the Center three times a week for treatment. Margaret Smith OTR, shown with Myron helps him ride his bike. He has a wagon filled with 20-pound weights to pull. As he gets stronger the weights are increased.

Above: Mr. Patton discusses a case with his wife, Gladys, the Center's social worker. They are standing in the entrance to the building. Just to their right is the electric eye that automatically opens the door.

Left: Blond 2½ year-old Rebecca Taylor, who has a scissors gait tries to follow the colored feet that Jane Brown, O.T.R., has placed on the mat.



Right: Jane Coffee, OTR, is showing Thomas Carroll how to weave a lightweight scatter rug on the floor loom. Mr. Carroll spends half a day at the Center and the other half at the Indiana Board for Industrial Aid to the Blind. The Center will accept three blind persons at a time for a 13-week period in the vocational training shop.

"Admitting then, the truth of the germ theory, and proceeding in accordance with it, we must, when dealing with any case, destroy in the first instance once for all any septic organisms which may exist within the part concerned; and after this has been done, our efforts must be directed to the ***prevention of the entrance of others into it."***

PORTRAIT: THE BETTMANN ARCHIVE

THE WORDS OPPOSITE were read by Joseph Lister before the British Medical Association in Dublin, August 9, 1867. Though they were received with lingering skepticism by many, they initiated the era of antiseptic surgery from which has evolved the concept of aseptic surgery as practiced today.

Lister's abiding concern with "the greatness of the evil of putrefaction in surgery" led him to experiment with first one technique of surgical antisepsis then another over a period of forty years. These techniques involved mainly the use of carbolic acid, applied by spray, or by packs and compresses of lint and other materials, and frequently topped with sheets of tin, lead, and ultimately oiled silk—all for the purpose of "keeping the outside world out" of the open wound.

That he succeeded in reducing surgical infection to an amazing degree—despite his primitive materials and facilities—is history.

Today we're likely to think that modern aseptic techniques and chemotherapeutic agents have largely eliminated the problem of "keeping the outside world out" of wounds. Yet daily we hear more about hospital cross infection and bacterial resistance to antibacterial agents. Recently, in discussing the overall problem of hospital infection, Robertson *et al.* (Am. J. Surg., Aug., 1956) said, "We have been investigating the use of some occlusive and some antiseptic dressings and believe that we have much to learn from the writings of Lord Lister seventy-five years ago."

Which brings us to recall the truism "There's nothing really new under the sun"—including Aeroplast. Lister long ago thought of, and achieved in a crude way, all the things we thought of and set out to achieve with Aeroplast as an antibacterial, occlusive surgical dressing.

Of course, modern technology has enabled us to add a few refinements and improvements which he couldn't anticipate and hope for, such as non-reactivity, flexibility, transparency, vapor permeability, not to mention the convenience and efficiency of application by aerosol spray.

Have you used Aeroplast? There is, we'll admit, a trick to using it, and if you're a regular user at present, you'll know what we mean. Spray it on *lightly*—just a swish over the area to be covered at a distance of *at least* 10-12 inches—let it dry for 30 seconds, then swish again *lightly*—that's all that's needed, and you'll avoid having it run or remain sticky.

Or there's another way of using it which is especially good in oozing or bleeding wounds (Wexler *et al.* Am. J. Surg., Oct., 1956). Spray one light coat, then apply a layer of gauze before the coat dries. Spray another coat, and apply a second layer of gauze and a third if necessary, depending on the amount of bleeding or oozing. The gauze will absorb the exudate, and when the time comes, the dressing is easily and cleanly removed.

There's an impressive bibliography on the use of Aeroplast in operative and traumatic surgery of all types. May we send you reprints? AEROPLAST CORPORATION, 420 Dellrose Avenue, Dayton 3, Ohio.

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HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P. H.

Bed Occupancy

BED occupancy is a barometer. When it rises or falls, it points out that certain conditions affecting the provision and use of services are changing. These indications are important for internal administration, operation, financing, and planning for hospital care.

Occupancy is an effective quantitative measurement of use of existing beds and services. It is not, however, an indication of quality of care; in fact, to regard it as such would be completely misleading.

Percentage of occupancy is perhaps the key statistical measurement of use of available facilities. It is the ratio of days of service given during a specific period of time to the maximum days of service which might have been rendered. It vividly portrays the relationship of supply and demand.

Theoretically, the ideal occupancy, of course, is zero. Hospitals in this sense are one of the few enterprises which strive to put themselves out of business. The ultimate goal of maximum community preventive service is the need for less and less beds. However, at the moment this goal is far from being realized; hence bed occupancy must be considered from the reverse point of view. In other words, the higher the occupancy the greater the indication of needs and the greater the indication that these needs are or are not being met.

What, then, do changes in bed occupancy mean? Several possibilities immediately come to the foreground. First, fluctuations in bed occupancy may mean changes in medical practice (for example, changes in length of patient stay resulting from early ambulation and use of the newer antibiotics tend to reduce bed occupancy, unless increased admissions make up for this reduction.

Secondly, changes in bed occupancy may indicate either an increase or decrease in *demand* for services. And the third point, which is really a corollary of the above, is that it reflects patterns of the *use* of hospital services. When occupancy is high, it may indicate overcrowding. When it is low, it may indicate underuse or even overbuilding.

Increasing costs of hospital care make it mandatory that existing hospital facilities be used to their best potential so as to spread the cost of providing services over as broad a base as possible.

Of course, this does not mean that facilities must be used at a 100 percent occupancy level to be efficient and/or effective.This is practically impossible, because of the time interval required to prepare a room and bed between the discharge of a patient and the admission of another patient to the same bed. It is also impossible because of the existing pattern separation of hospitals into many clinical departments whose use is not interchangeable.

There is, however, a level of occupancy that is desirable and effective from an operational point of view. For general hospitals this is said to be around 80 percent; for mental and tuberculosis hospitals it approximates 90 percent.

Average levels of occupancy are not the same for all hospitals. Not only do variations exist between types of hospitals, but they also exist between hospitals by types of control. Of even more immediate practical importance to individual hospital operation are differing levels of occupancy by size of hospital and by type of accommodation (private, semiprivate, and ward). All these possible variations must be taken into consideration to understand what is happening in hospital use.

Percentage of occupancy varies with:

TIME: Information on annual averages of percentages of occupancy is available since 1929. Between that year and 1954 all hospital groups and types showed considerable variation. The pattern for all hospitals more nearly resembles that of government hospitals. The trend in both nonprofit and proprietary hospital groups is toward a higher rate of occupancy. Increased utilization indicates increased demand for services, which in turn is related to the economic ability of the population to pay for such care.

CONTROL: Government hospitals generally show a higher percentage of bed occupancy than either nonprofit or proprietary groups. Among the government controlled hospitals, state hospitals showed the highest percentage of occupancy, with local government hospitals ranking second and federal hospitals third.

Among the nonprofit hospitals, church hospitals show a higher occupancy than nonprofit association-controlled hospitals since 1941. Prior to that date the situation was reversed (see Chart 1 and Table 1).

TYPE OF SERVICE: Nervous and mental institutions show the highest percentage of occupancy—almost 96 percent. This high rate reflects the great need for such services and facilities. Such a high rate of occupancy could not be maintained for any appreciable period of time in general hospitals, because of the relatively short length of patient stay and the resulting rapid turnover of patients as compared with the long period of stay of nervous and mental patients.

Tuberculosis hospitals showed the next highest rate of occupancy (83 percent), and general hospitals were third with 74 percent. Special hospitals, such as maternity, industrial, eye, ear, nose and throat, children's and isolation hospitals, had a lower percentage of occupancy, on the average, than the general hospitals.

It is interesting to note that orthopedic hospitals had a higher occupancy rate than general hospitals or the other special hospitals. Length of patient stay may be the factor responsible for this. But this occupancy rate was less than the rate for nervous and mental or tuberculosis hospitals (see Chart 2 and Table 2).

SIZE: Generally speaking, the larger the hospital the higher the rate of occupancy. There are many reasons for this. Probably the most important one is the ability of the larger hospitals to provide a greater variety of services and therefore attract a larger potential popula-

(Continued on next page)

TABLE 1.
Percentage of Bed Occupancy by Control Type
1929 - 1954*

Year	Total Hospitals	GOVERNMENT				NONPROFIT ASSOCIATION			
		Total	Federal	State	Local	Total	Church	Nonprofit	Proprietary
1954.....	85	90	84	95	79	73	74	73	67
1953.....	85	89	80	95	80	74	73	75	66
1952.....	85	90	81	95	80	75	74	76	67
1951.....	85	89	77	95	81	75	76	75	66
1950.....	85	90	78	95	83	75	77	75	65
1949.....	85	89	80	94	82	76	78	75	65
1948.....	86	89	80	94	80	78	80	76	68
1947.....	85	88	79	93	79	81	84	78	69
1946.....	84	87	81	92	76	80	84	77	67
1945.....	81	82	72	94	74	78	82	75	64
1944.....	75	75	55	94	74	76	80	74	67
1943.....	76	77	56	94	76	75	78	73	64
1942.....	81	85	67	93	77	75	75	74	60
1941.....	82	86	66	94	81	73	73	73	61
1940.....	84	90	80	94	82	71	70	71	57
1939.....	84	90	84	94	83	69	68	69	55
1938.....	83	90	82	95	82	68	67	69	54
1937.....	84	91	83	95	84	70	69	70	55
1936.....	83	91	82	95	85	66	65	66	53
1935.....	81	91	78	95	85	62	61	63	51
1934.....	79	90	75	95	84	59	56	60	45
1933.....	79	90	75	95	84	—	55	—	—
1932.....	80	90	78	94	83	—	60	—	—
1931.....	80	89	76	94	85	—	63	—	—
1930.....	80	89	79	94	80	—	64	—	—
1929.....	80	89	77	94	78	—	67	—	—

*Computed from data in Annual Hospital Numbers of the **Journal of The American Medical Association** and **Administrators Guide Issue, 1955, Hospitals,** Journal of the American Hospital Association.

TABLE 2.
Percentage of Bed Occupancy by Type of Service
1929 - 1954‡

Year	General	Nervous & Mental	Tuberculosis	Maternity	Industrial	EENT	Children's	Orthopedic	Isolation	Convalescent & Rest	Hospital Department of Institution	All Other Hosp.
1954.....	73	96	83	64	—	58	71	76	53	88	—	67
1953.....	73	96	85	72	66	58	69	73	47	78	70	89
1952.....	74	96	84	61	67	57	68	73	41	73	67	81
1951.....	74	96	83	64	67	58	67	78	54	71	66	92
1950.....	74	97	84	65	68	58	67	79	47	71	64	87
1949.....	75	96	83	66	65	61	69	77	44	73	62	86
1948.....	76	96	81	65	70	60	69	73	47	72	64	86
1947.....	77	96	77	72	64	61	71	73	44	72	65	86
1946.....	77	94	74	70	62	62	73	72	46	59	64	93
1945.....	72	95	76	66	62	61	73	72	38	73	63	88
1944.....	62	95	79	66	62	55	69	68	35	58	65	88
1943.....	62	95	82	64	60	55	65	71	39	66	66	89
1942.....	68	94	85	71	56	55	67	75	33	82	66	81
1941.....	68	95	86	65	56	55	68	77	33	83	76	86
1940.....	70	95	86	63	54	54	68	76	42	78	71	80
1939.....	69	95	86	64	50	54	68	75	37	79	73	83
1938.....	69	95	87	62	50	54	70	79	41	74	68	65
1937.....	70	96	84	64	55	57	69	81	43	71	66	88
1936.....	67	96	86	64	49	53	65	81	42	69	71	84
1935.....	64	96	86	58	46	48	64	78	45	71	67	87
1934.....	60	95	85	61	43	45	67	78	39	66	66	79
1933.....	60	95	85	61	44	46	66	77	41	69	60	79
1932.....	63	95	85	64	47	50	68	79	39	67	63	74
1931.....	64	95	85	59	48	52	70	78	37	72	64	69
1930.....	65	95	85	63	53	53	67	84	33	68	66	78
1929.....	66	95	83	63	55	48	66	80	36	71	63	75

‡Computed from data in Annual Hospital Numbers of the **Journal of The American Medical Association** and **Administrators Guide Issue, 1955, Hospitals,** Journal of the American Hospital Association.

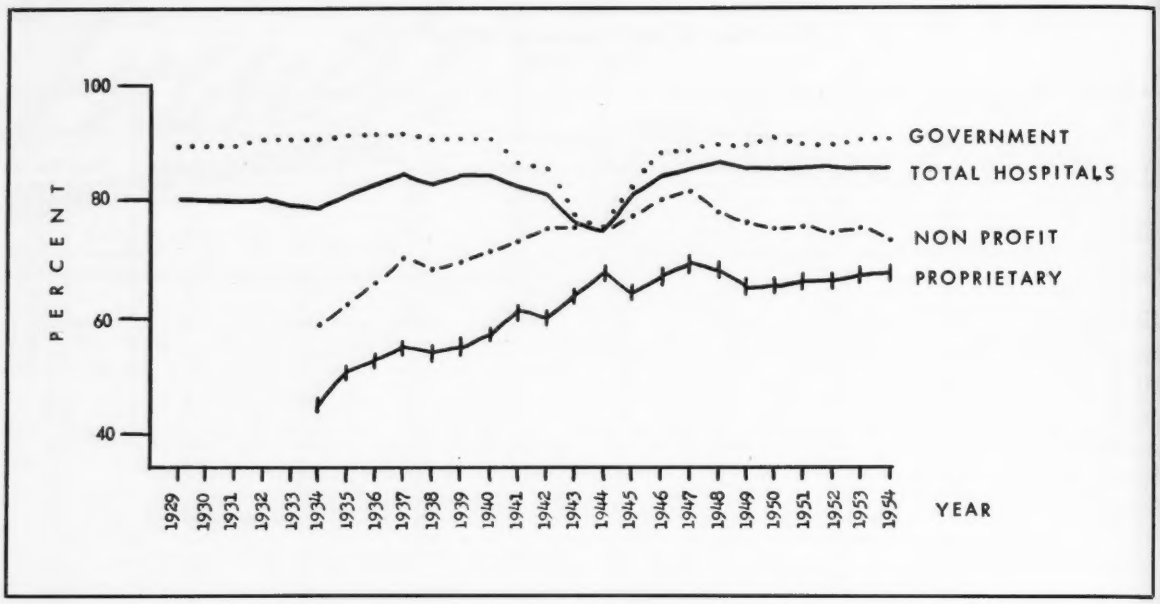


Chart 1. Percentage of bed occupancy in hospitals by control, 1929-1954.*

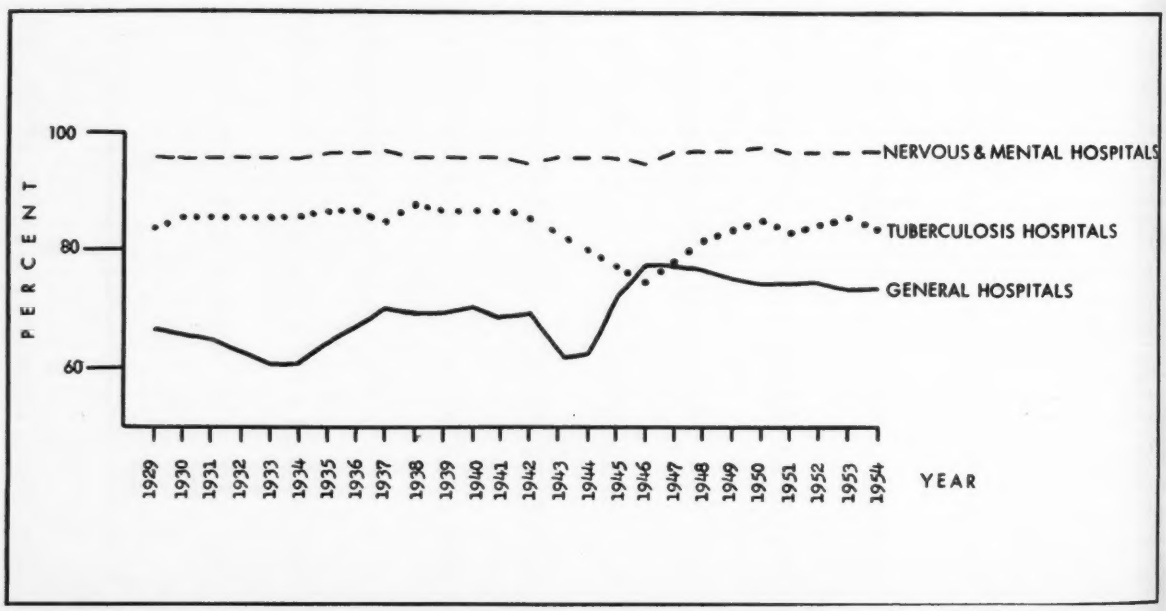
HOSPITAL TRENDS Continued

tion. Another reason for this variation by size of hospitals can be traced to the practice of allocating hospital beds to specific categories of services such as maternity and pediatrics. This practice is more restrictive in its relationship to available beds in the smaller hospitals (see Chart 3).

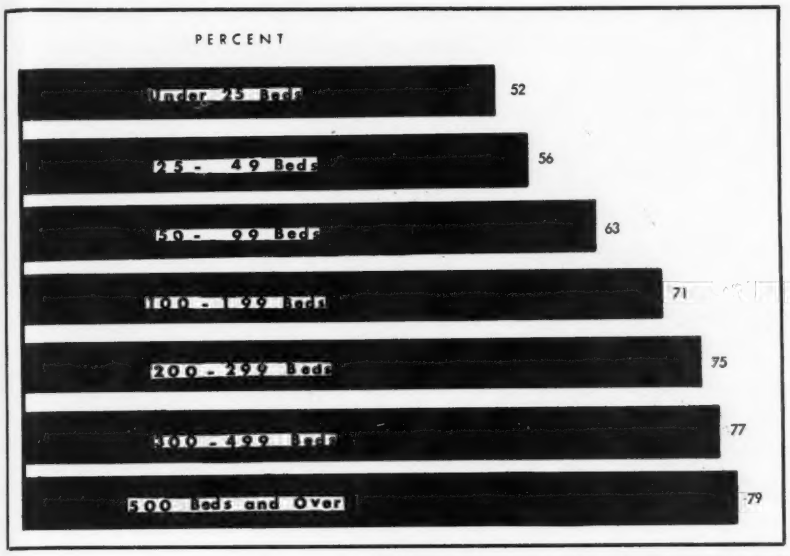
ACCOMMODATION: Although general data on percentage of bed occupancy by type of accommodation is not available for all hospitals, certain analyses made by the United Hospital Fund of New York for its member hospitals indicate that occupancy is highest in the semi-private accommodations, with ward and private being almost the same (see Chart 4).

SEASON: Occupancy is highest during the winter months and lowest during the summer months. This has been explained by the increased prevalence of respiratory infections requiring hospitalization during the winter months, the decreased use of hospitals for children's services in the summer, and the drop in elective procedures during the summer vacation season (see chart 5).

Chart 2. Percentage of bed occupancy in hospitals by type of service, 1929-1954.*

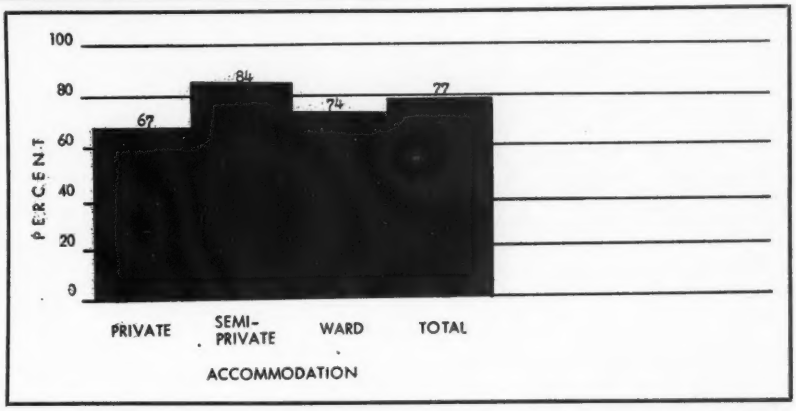


*Computed from data in Annual Hospital Numbers of the **Journal of the American Medical Association** and **Administrators Guide Issue, 1955, Hospitals**, Journal of the American Hospital Association.

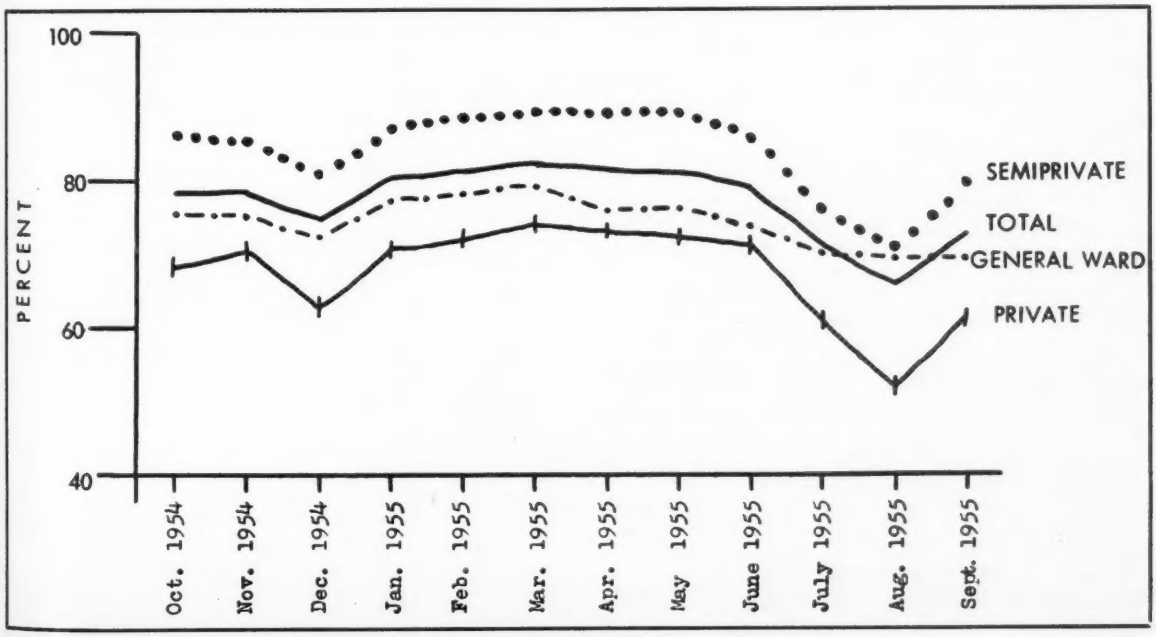


Left: Chart 3. Percentage of occupancy in all general and special short-term hospitals by size of hospital — 1954.*

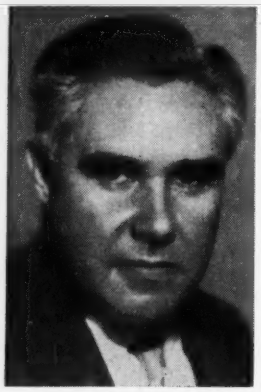
Right: Chart 4. Voluntary general hospitals in New York City. Percentage occupancy by type of accommodation, October 1, 1954-September 30, 1955.**



Below: Chart 5. Voluntary general hospitals in New York City. Summary of Trend of Percentage of Occupancy (excluding nursery bassinets), October, 1954-September 30, 1955.**



*Administrators Guide Issue, 1955, Hospitals, Journal of the American Hospital Association.
**United Hospital Fund of New York, Bulletin Number 177; November 17, 1955.



John G. Steinle

The Nursing Problem

A New Series

By John G. Steinle

Mr. Steinle, well-known hospital consultant, has joined the staff of HOSPITAL TOPICS as consulting editor. In charge of hospital work for Cresap, McCormick and Paget for three and a half years, he recently opened his own office in Garden City, New York. Prior to that, Mr. Steinle served as hospital program director for the New York and Boston regional offices of the Public Health Service. He is familiar with all phases of hospital planning, management and administration.

● Nearly all persons concerned with medical education agree that there are many complex problems relating to nursing and nursing education. There is little agreement, however, as to the solution of these problems — or even on the facts relating to them. Often the facts, if superficially considered, can be misleading.

AVAILABILITY OF NURSES

The ratio of active graduate nurses to population has increased in every decade, from 55 nurses per 100,000 population in 1910 to 249 per 100,000 in 1950. In 1920 active graduate nurses were less numerous than physicians. Since 1930 they have outnumbered physicians; today there are approximately two active graduate nurses to each physician. Superficial review of these statistics would indicate that if there is a shortage of professional nurses the problem is rapidly being solved. This, however, is not the whole story.

The number of nurses employed by federal agencies has multiplied sevenfold since 1930 — from 4,703 to 31,164. The number of active nurses in new-hospital employment has increased from nine percent in 1930 to 25 percent in 1955. Non-hospital employment does not include private-duty nurses who today are principally employed in hospitals.

It is not possible to determine what percentage of active nurses are part-time. We may infer that the number of part-time nurses is on the up-trend from the increasing proportion who are married and have families. In 1920, only 11 percent of the active nurses were married. Today approximately half are married.

UTILIZATION OF NURSES

While the total number of active graduate nurses has increased, the rate of increase has been decreasing. There was a 79 percent increase from 1920 to 1930, a 23 percent increase from 1930 to 1940, and only a 15 percent increase from 1940 to 1950.

In 1932 there was an average of 15 registered nurses employed in general hospitals per 100 patients. In 1955 there were 29.5 registered nurses per 100 patients. Thus the ratio of nurses to patients in general hospitals has doubled since 1932. In addition to the fact that the average working week of nurses has decreased by 23 percent since 1932, modern technics and quality of patient care require more nursing personnel. Also, there is less utilization of student nurses in patient care.

The questions that are constantly being asked are: How much more graduate nursing time is required than previously? How effective is graduate nursing today? How much work is being performed by graduate nurses that does not require their skills?

COST OF NURSING CARE

Nurses' incomes, according to Bureau of Census information, doubled from 1939 to 1949. It is estimated that they have increased by 60 percent since 1949. This increase is not inconsistent with the income increase of other occupations employing a majority of women. As previously indicated, however, more nurses are required per patient. This is also responsible for increases in the cost of nursing per patient day from $1.85 in 1935 to $5.20 in 1954.

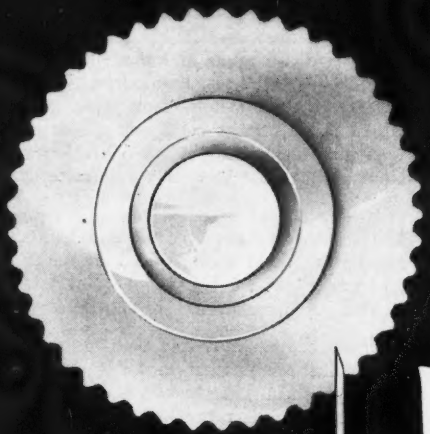
NURSING EDUCATION

One of the principal reasons that the ratio of registered nurses to patients has doubled since 1932 is the restriction on the use of student nurses in providing patient care. The nursing profession has been largely responsible for changing the clinical experience of students from repetitious functions required in care of the patient, to a limited number of tasks necessary to provide educational experiences. Standards, other than those relating to clinical experience, have also been raised in hospital schools of nursing.

As a result, many hospitals have complained that it is no longer economically feasible to operate schools of nursing. The fact that hospitals still utilize student nursing personnel is demonstrated by the fact that in New York City in 1954, the per diem cost of nursing service in hospitals with nursing schools was $5.30 (excluding training school costs), while for hospitals without nursing schools the per diem cost was $5.65.

The loss of students before graduation is a serious problem in nursing. For every three girls admitted, schools of nursing graduate only two. Many schools complain that they do not have a sufficient number of applications to permit effective screening. There apparently are a number of reasons for the decreased interest in the nursing profession. There is a need to isolate and examine these problems.

(Continued on next page)



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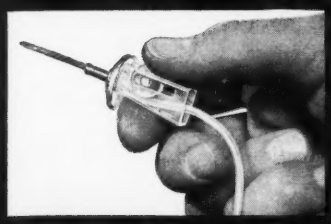

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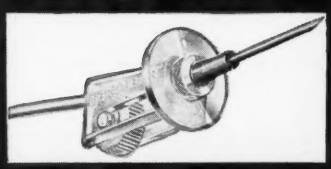

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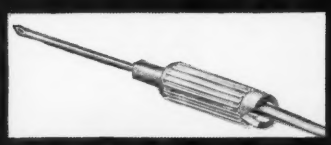

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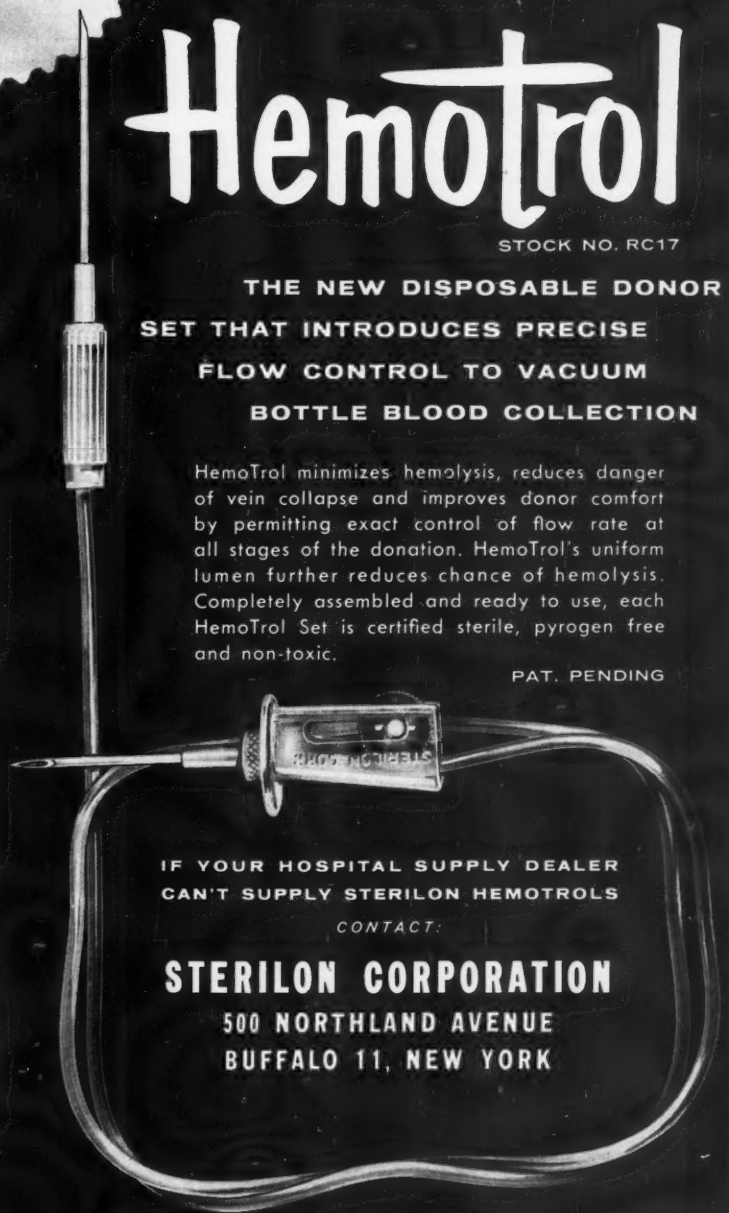

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The number of schools of nursing has declined from 1,884 in 1930 to 1,083 this year. The educational quality of the schools has increased as indicated by the fact that in 1950, 92 percent had full-time instructors, in contrast with 54 percent in 1924. A decline in the ratio of students to full-time instructors has made it possible for schools to provide more specialized instruction.

The increasing cost of nursing education, the decreased return in student time to the hospital and an attempt by nursing associations to improve the education level of members of the profession, are pressures for establishing nursing education as a non-hospital-sponsored activity. There are substantially more collegiate programs of nursing than there were 10 years ago. Some educators have suggested that nursing should be more functionalized — with head nurses and supervisors trained in four-year collegiate programs, general duty nurses in junior colleges (two-year programs) and practical nurses in special one-year programs. There are several pilot studies now under way designed to evaluate this proposal.

This general article introduces a series concerned with the problem of hospital nursing and nursing education. HOSPITAL TOPICS will present — impartially — each major facet of this controversial subject. Your comments and contributions are invited.

COMING NEXT MONTH

The present-day hospital is one of the most complex organizations. It brings together, under a single roof, all areas of human knowledge — all of the physical sciences, humanities, and business administrative know-how. It represents an operation which is of utmost community concern. Its objectives are idealistic, yet its operation must be efficient and it must be wisely administered.

A hospital, to be effective, must be planned and administered to meet the needs of the specific community which it serves. Each hospital has an individuality shaped by the characteristics and particular problems of its service area.

There are no cure-alls or panaceas in the field of hospital administration, but there are some principles which must be known and understood in order that the administrator and department heads may effectively cope with the myriad problems of this complex organism — today's hospital. While these principles apply to all hospitals, they are modified by such factors as size and ownership.

In order to identify the underlying principles for sound hospital administration the Community Hospital Section of the Association of Western Hospitals developed a lecture series oriented particularly for the community hospitals of less than 150 beds.

This series has been presented a number of times at seminars in the western states, and has been enthusiastically received. HOSPITAL TOPICS has been asked to publish this material by a number of its readers, who have either been present during the presentations of this series of principles or have heard of it.

HOSPITAL TOPICS has obtained permission from John H. Gorby, Chairman, Community Hospital Section of the Association of Western Hospitals, to publish this series. Mr. Gorby, administrator of La Mesa (Calif.) Community Hospital, was responsible for the development of the lecture series.

The first article of this series will be presented next month.

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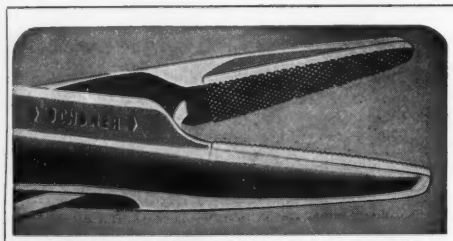
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Ready Reference of Hospital Facts

For Planning and Operation

Part VIII

By Louis Block, Dr., P.H.

The Average Nonprofit Long-Term General Hospital in the United States

● From 1946 to 1954 the activities of the long-term general hospitals in the United States have changed. This is especially true when one notes the following changes that have occurred in the number of facilities available, their utilization, finances, and personnel. These hospitals now account for 5.8 percent of all hospitals, 4.5 percent of all beds, 4.5 percent of the average days of care provided, 0.7 percent of all admissions, and 3.6 percent of all expenses.

Facilities:

1. The number of hospitals has increased by 17 (from 389 to 406)—an increase of 4.4 percent.

2. The number of beds has decreased by 12,489 (from 83,415 to 70,926)—a decrease of 15.4 percent.

Utilization:

1. The average daily census has decreased by 1,937 (from 62,804 to 60,867)—a decrease of 3.1 percent.

2. The percentage of occupancy has increased from 75.3 percent to 85.8 percent.

3. The number of admissions has increased by 15,883 (from 139,332 to 155,215)—an increase of 11.4 percent.

Finances:

1. Total assets have increased $79,543,000 (from $342,932,000 to $422,475,000)—an increase of 23.2 percent.

2. Total expenses have increased $121,433,000 (from $68,149,000 to $189,582,000)—an increase of 17 percent.

3. Total expenses per patient day have increased $5.56 (from $2.97 to $8.53)—an increase of 187.2 percent.

4. Payroll expense has increased $87,488,000 (from $37,691,000 to $125,179,000)—an increase of 232.0 percent.

5. Payroll expense per patient day has increased $3.99 (from $1.64 to $5.63)—an increase of 243.3 percent.

Personnel:

1. The number of full-time personnel has increased by 18,294 (from 28,000 to 46,294)—an increase of 65.3 percent.

2. The number of full-time personnel per 100 patients has increased by 31 (from 45 to 76)—an increase of 68.9 percent.

The following presents some pertinent facts concerning the average long-term general hospital in the United States.

The Average Nonprofit Long-Term General Hospital in the United States*

Facilities:

1. Number of beds	98
2. Number of bassinets	2
3. Percent of hospitals with infant incubators	14.5
4. Number of incubators	2
5. Number of major operating rooms	1.4
6. Number of minor operating rooms	1.4

Utilization:

1. Number of annual adult admissions	262
2. Average daily adult census	80
3. Percentage occupancy	81.9
4. Average length of adult stay in days	111.6

Financial:

1. Total assets	$1,094,787
2. Plant assets	$680,140
3. Percent plant assets of total assets	62.1
4. Total annual expenses	$316,036
5. Total expenses per patient day	$10.80
6. Annual payroll	$195,457
7. Payroll per patient day	$6.68
8. Percent payroll of total expenses	61.9
9. Percent hospitals requiring funds for replacement	56.3
10. Number of $ per hospital required for replacement	$250,037

Services:

1. Percent of hospitals offering:	
a. Blood bank	9.9
b. Cancer clinic	4.4
c. Central supply room	29.6
d. Children's education program	53.7
e. Clinical laboratory	55.2
f. Dental department	52.2
g. Electrocardiograph	37.9
h. Electroencephalograph	5.4
i. Hospital auxiliary	46.8
j. Library, medical	41.9
k. Library, patient	69.5
l. Medical record department	64.0
m. Mental hygiene clinic	6.9
n. Metabolism apparatus	25.6
o. Occupational therapy department	61.1

*Based on information in American Hospital Association's Administrators Guide Issues (1951-1955).

p. Outpatient department	51.2
q. Pharmacy	26.6
r. Physical therapy department	64.5
s. Postoperative recovery room	15.3
t. Premature nursery	3.0
u. Radioactive isotopes	2.5
v. Rehabilitation department	30.5
w. Social service department	51.7
x. X-ray diagnosis	55.2
y. X-ray, routine chest, on admission	31.0
z. X-ray therapy service	9.4
aa. Organized training programs for auxiliary nursing personnel	8.3

Personnel:

1. Number of full-time personnel	82
2. Number of full-time personnel per 100 patients	102
3. **Nursing personnel:**	
a. Total graduate nursing personnel	15
(1) Administrative graduate nursing personnel	2
(2) Full-time instructors	0
(3) Supervisors and assistants	3
(4) Head nurses and assistants	3
(5) General duty nurses, full-time	5
(6) General duty nurses, part-time	2
(7) Nurses not classified	1
b. Private duty nurses	1
c. Practical nurses	14
d. Attendants	29
e. Nurses' aides	19
f. Ward maids	8
g. Orderlies	5
4. **Medical technologists:**	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	2
d. Other part-time	0
5. **X-ray technicians:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
6. **Occupational therapists:**	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
7. **Physical therapists:**	
a. Registered full-time	3
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
8. **Dietitians:**	
a. Full-time	1
b. Part-time	0
9. **Medical social workers:**	
a. Full-time	4
b. Part-time	0
10. **Pharmacists:**	
a. Full-time	1
b. Part-time	1
11. **Medical record librarians:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
12. **Other medical record personnel:**	
a. Full-time	1
b. Part-time	0

— DEPARTMENTAL —

Governing board:

1. Number of members	17

Medical staff:

1. Percent hospitals with chief of staff	93.0
2. Percent hospitals with chiefs of services	55.0
3. Percent hospitals with written set of staff regulations	60.2
4. Percent hospitals with regularly scheduled meetings of staff	66.7
5. Percent hospitals with standing committees of the staff	43.9
6. Percent hospitals with executive committee of staff	37.9
7. Percent hospitals with medical record committee of staff	24.4
8. Percent hospitals with credentials committee of staff	23.0
9. Percent hospitals with tissue committee of staff	7.4
10. Percent hospitals with education committee of staff	14.7
11. Percent hospitals with pharmacy committee of staff	7.8
12. Percent hospitals with dietary committee of staff	10.6
13. Percent hospitals with nursing committee of staff	17.1
14. Percent hospitals with other committees of staff	8.8
15. Number of staff physician appointments	31
16. Number of active staff	14

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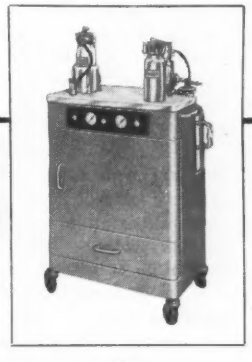

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17. Number of active staff per 100 beds	14
18. Number of associate staff	3
19. Number of associate staff per 100 beds	3
20. Number of courtesy staff	4
21. Number of courtesy staff per 100 beds	4
22. Number of consultant staff	9
23. Number of consultant staff per 100 beds	9
24. Number of honorary staff	0
25. Number of honorary staff per 100 beds	0
26. Number of other staff appointments	1
27. Number of other staff appointments per 100 beds	1
28. Percent hospitals having psychiatrist on staff	63.0
29. Percent hospitals reporting surgical restrictions on staff	57.7
30. Percent hospitals permitting non-staff members to practice in hospital	30.6
31. Percent hospitals providing examining rooms for ambulatory patients of medical staff	17.2
32. Percent hospitals having private physicians' offices in hospital or on hospital grounds	6.6
33. Percent hospitals have x-ray facilities available to private ambulatory patients of staff	32.3
34. Percent hospitals having laboratory facilities available to private ambulatory patients of staff	28.6
35. Percent hospitals accredited by the Joint Commission on Accreditation of Hospitals	30.8

Administrator:

1. Percent hospitals in which chief administrative officer is a physician	8.5
2. Percent hospitals in which chief administrative officer is a graduate nurse	47.6
3. Percent hospitals in which chief administrative officer is other than a physician or nurse	43.9
4. Percent hospitals in which chief administrative officer is a graduate of college course in hospital administration	11.0
5. Percent hospitals in which chief administrative officer is a male	41.6
6. Percent hospitals in which chief administrative officer is a female	58.4
7. Percent hospitals in which one or more persons perform full-time as assistant administrator	45.9
8. Percent hospitals having administrative staff member on duty at night	33.8
9. Percent hospitals delegating administrative responsibility to night supervising nurse	57.4

Laboratory:

1. Percent hospitals having all tissue removed at surgery routinely examined by a pathologist	65.4
2. Percent hospitals having urinalysis on all admissions	74.7
3. Percent hospitals having blood count on all admissions	64.8
4. Percent hospitals having serological examinations for syphilis on all adult admissions	42.0
5. Percent hospitals having electrocardiographs on all admissions over 45 years of age	13.0
6. Percent hospitals having Rh grouping on all pregnancy cases	9.9
7. Percent hospitals having preoperative blood grouping on all surgical cases	13.0
8. Percent hospitals having preoperative coagulation on all tonsillectomies	8.6
9. Percent hospitals having postoperative urinalysis on all surgical cases	14.2
10. Percent hospitals having no tests without doctors' orders	22.8

Pharmacy:

1. Percent hospitals operating pharmacies	25.6
2. Of those hospitals operating pharmacies, percent having full-time licensed pharmacist	51.1
3. Of those hospitals operating pharmacies, average number of full-time pharmacists	1.3
4. Of those hospitals operating pharmacies, percent manufacturing parenteral solutions	11.1
5. Percent of hospitals having formulary	51.1

Outpatient Department:

1. Percent hospitals having one or more outpatient clinics	58.0
2. Number of annual clinic visits	4,149
3. Number of annual private outpatient visits	4,753
4. Number of annual emergency visits	388

Medical Records:

1. Percent hospitals microfilming medical records	1.1
2. Number of annual deaths	41
3. Number of annual autopsies	8
4. Percent autopsies of deaths	20.4
5. Number of annual deaths released to legal authorities	5
6. Percent hospitals using Standard Nomenclature of Diseases and Operations	79.8

Admitting:

1. Percent hospitals using typewriter system for duplicating admitting records	67.1
2. Percent hospitals using Mimeograph system for duplicating admitting records	1.8
3. Percent hospitals using liquid and gelatin system for duplicating admitting records	1.2
4. Percent hospitals using plate imprint system for duplicating admitting records	0.6
5. Percent hospitals using hand entry system for duplicating admitting records	15.6
6. Percent hospitals using other systems or combinations of above for duplicating admitting records	13.7
7. Percent hospitals routinely treating:	
a. Alcoholics	3.6
b. Cancer	25.9
c. Cardiac	43.5
d. Dermatologic	21.8
e. Drug addiction	1.6
f. Epileptic	13.0
g. Gynecologic	13.0
h. Isolation (Contagion)	4.7
i. Leprosy	0.5
j. Medical	40.4
k. Mental deficient	7.8
l. Neurologic	24.4
m. Obstetric	13.0
n. Ophthalmic	17.1
o. Orthopedic	64.2
p. Otorhinolaryngologic	15.0
q. Poliomyelitis	33.2
r. Psychiatric	8.8
s. Surgical	22.3
t. Tuberculosis	6.7
u. Urologic	22.8
v. Venereal disease	3.1
w. Acutely ill	22.6
x. Chronically ill	50.0

y. Students exclusively	0.0
z. Convalescent and rest	50.0
aa. Geriatric	27.9
bb. Industrial	3.2
cc. Pediatric	46.8
dd. Prisoners exclusively	0.0

Accounting:

1. Percent hospitals with ending date of fiscal year in:	
a. January	0
b. February	8.6
c. March	5.2
d. April	5.7
e. May	1.7
f. June	10.9
g. July	0.6
h. August	1.7
i. September	5.7
j. October	3.4
k. November	1.1
l. December	55.4
2. Percent hospitals which calculate depreciation	52.7
3. Percent hospitals which fund depreciation	30.4
4. Percent hospitals operating under formal budgets	75.8
5. Percent hospitals using AHA chart of accounts	36.7

Purchasing:

1. Percent hospitals with central purchasing department	74.9
2. Percent hospitals with central purchasing departments with full-time purchasing agent	18.3
3. Percent hospitals with central purchasing department with part-time purchasing agent	68.7
4. Percent hospitals with central purchasing department with no reply as to purchasing agent	13.0

Public Relations:

1. Percent hospitals using booklet for employees	13.5
2. Percent hospitals using booklet for patients	18.0
3. Percent hospitals using regularly published house organ	2.2
4. Percent hospitals using printed annual report	14.1
5. Percent hospitals using patient opinion poll	6.2
6. Percent hospitals using personnel opinion poll	7.9
7. Percent hospitals using medical staff opinion poll	4.5
8. Percent hospitals using community opinion poll	0
9. Percent hospitals using none of these	87.6

Dietary:

1. Percent hospitals with central food service layout	91.1
2. Percent hospitals with decentralized food service layout	8.9
3. Percent hospitals with selective menus for all patients	16.8
4. Percent hospitals with selective menus for private patients only	4.4
5. Percent hospitals not offering selective menus	78.8
6. Percent hospitals with manual and centralized dishwashing	18.3
7. Percent hospitals with manual and decentralized dishwashing	7.7
8. Percent hospitals with mechanical and centralized dishwashing	66.3
9. Percent hospitals with mechanical and decentralized dishwashing	10.7

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen	52.4
a. Number of pounds processed per week	8,977
b. Number of pounds processed per patient day	7.8
2. Percent hospitals operating own laundry and processing only a part of soiled linen	10.7
a. Number of pounds per week	1,464
b. Number of pounds per patient day	5.7
3. Percent of hospitals not operating own laundry	36.9
a. Number of pounds processed per week	1.661
b. Number of pounds processed per patient day	4.2

Auxiliaries:

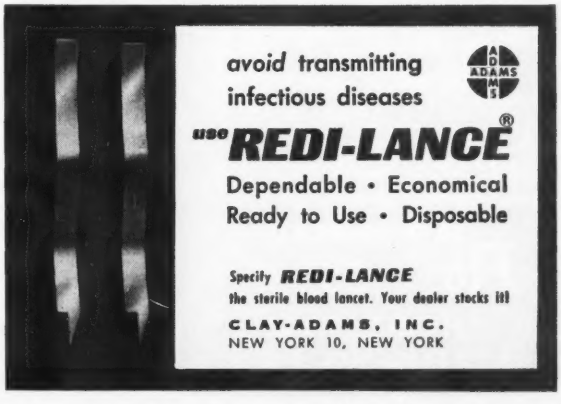
1. Percent hospitals having organized auxiliaries	53.6

Safety:

1. Percent hospitals with organized safety committee	44.3
2. Percent hospitals with written fire emergency and evacuation plans	69.3
3. Percent hospitals with regularly scheduled fire drills	50.6
4. Percent hospitals having own written plan for mobilization of employees and medical staff	34.1
5. Percent hospitals whose written plan is integrated in Master Community Plan	31.8
6. Percent hospitals represented on a Community Disaster Planning Committee	48.2

Religious:

1. Percent hospitals with a chapel	43.5
2. Percent hospitals with a meditation room for prayer	28.3
3. Percent hospitals with organized visiting clergy staff	37.7
4. Percent hospitals having chaplains available	80.0
5. Percent hospitals with full-time chaplains	18.4
6. Percent hospitals with part-time chaplains	21.6
7. Percent hospitals with chaplain on call only	38.4



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- 4 oz. Transparent Flo-master Ink
- 2 oz. Flo-master Cleanser
- 5 Assorted Felt Tips
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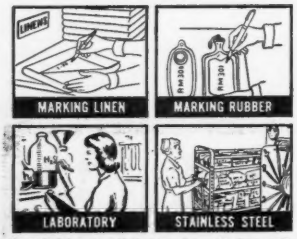

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TRADE TOPICS...

Ohio Chemical & Surgical Honors R. H. McElrath

R. H. McElrath, assistant to vice-president of sales, Ohio Chemical & Surgical Equipment Co., Madison, Wis., was honored at a banquet upon his retirement after 37 years of service.

R. E. Lenhard, president of the firm, presented him with a plaque. W. A. Lunger, vice-president of sales, presented a portable radio given by his company associates.

Mr. McElrath represented Ohio Chemical in the development of high-altitude oxygen breathing apparatus at Wright Field Aero Medical Research Laboratory during World War II.

Schenley Laboratories Promotes Ruskin

Murray Ruskin has been appointed district manager, western Great Lakes district, Schenley Laboratories. He will supervise the metropolitan Chicago area, Indiana, and western Michigan.

American Hospital Supply Acquires Dade Reagents

All the capital stock of Dade Reagents, Inc., Miami, Fla., has been acquired by American Hospital Supply Corp., Evanston, Ill.

Management of the company will continue under its present president, J. J. Griffitts, M.D.

Upjohn Names Allen Vice-President

W. F. Allen has been appointed vice-president for marketing, The Upjohn Co. Formerly he was vice-president and director of sales. Richard S. Schreiber, M.D., formerly vice-president and director of research, has been appointed vice-president for scientific administration. Dr. F. A. Eberly has been appointed executive director of development and manufacturing. Formerly he was director, production division.

C. R. Bard, Inc. Appoints Larsen

David C. Larsen has been appointed representative, C. R. Bard, Inc. His headquarters will be in Minneapolis. His territory will include North Dakota, South Dakota, Iowa, Minnesota, Nebraska, and part of Wisconsin. Formerly he was district sales manager, Landers, Frary & Clark.

Service Plan For Scientific Instruments Offered

A service and repair policy similar to that offered to television set owners has been announced to scientific instrument users by Chicago Apparatus Co.

Regular preventative maintenance will be carried on, and emergency repairs will be made at no extra charge to the customer.

Pharmaseal Appoints Sales Manager

Samuel L. Say has been appointed sales manager, Pharmaseal Laboratories, Glendale, Calif.

Formerly he was sales manager, Mishawaka Rubber and Woolen Co., a subsidiary of U. S. Rubber.

Pratt Promoted At Abbott Labs.

William D. Pratt has been named advertising manager of Abbott. Formerly he was creative director with the company.

Robert F. Beine, copywriter with Abbott since 1952, succeeds him as creative director.

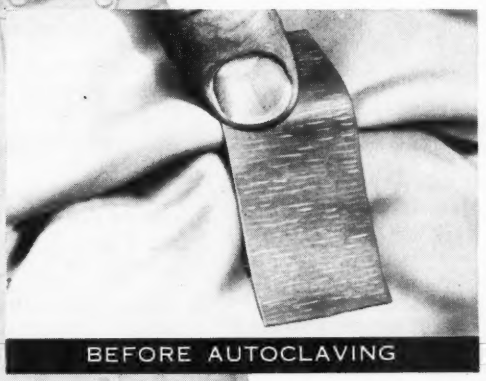
(Continued on page 86)

You're always sure

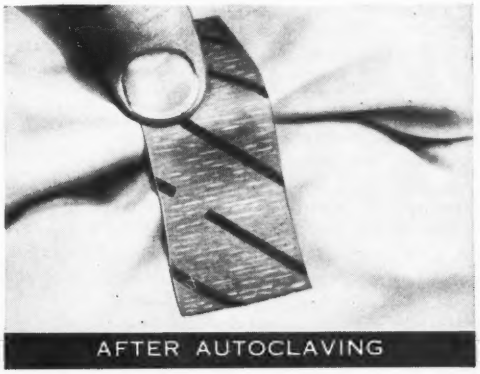
with "SCOTCH" Brand Hospital Autoclave Tape No. 222

- Tells at a glance whether pack has been through autoclave*
- Holds firmly in high steam temperatures
- Leaves no stains or gummy residue
- Sticks at a touch, takes pencil or ink markings.

*THIS IS NOT POSITIVE PROOF OF STERILITY, OF COURSE — NOTHING ON THE OUTSIDE OF A BUNDLE CAN PROVE THAT.



BEFORE AUTOCLAVING



AFTER AUTOCLAVING

BEFORE AUTOCLAVING. Here is "SCOTCH" Brand Hospital Autoclave Tape No. 222 on a bundle ready for the autoclave. This new tape seals packs firmly in half the time required for pinning, tying or tucking. And you can write on it with pencil or ink.

AFTER AUTOCLAVING. Unmistakable diagonal markings appear to tell you the pack has been through the autoclave. The special inks used in "SCOTCH" Hospital Autoclave Tape **cannot be accidentally activated** by sunlight or radiator heat . . . **only high steam temperatures** can bring them out!

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Personally Speaking

George Adams—has been appointed assistant director, Methodist Hospital of Brooklyn, New York.

Robert K. Adler—has been named assistant director, Jewish Hospital of Brooklyn, New York.

Dan Altshuler—has been appointed administrator, C. J. Harris Community Hospital, Sylva, N.C.

William Henry Andrews— has been appointed administrator, George W. Hubbard Hospital, Nashville, Tenn.

W. E. Arnold—has been appointed administrator, Scott and White Memorial Hospitals, Temple, Tex. He was formerly business manager, Baylor University Hospital, Dallas.

Royce Ashcraft—has been appointed administrator, Sid Peterson Memorial Hospital, Kerrville, Tex. He was formerly manager, Stephenville (Tex.) Hospital and Clinic.

Marshall G. Ause—has been appointed administrator, Lutheran Hospital of Manhattan, New York City, in addition to his duties as administrator, Norwegian Lutheran Deaconesses' Home and Hospital, Brooklyn, N.Y. These hospitals have merged under the corporate title, Our Saviour's Lutheran Hospitals. **Louise Wagner** remains as resident administrator, Lutheran Hospital of Manhattan.

Merle S. Bacastow, M.D.—has been appointed director, medical education, Methodist Hospital, Indianapolis, Ind.

Howard R. Bierman, M. D.—has been appointed medical and scientific director, City of Hope Medical Center, Los Angeles. He was formerly director, City of Hope's Hospital for Tumors and Allied Diseases, and Medical Research Institute.

Richard F. Binning—has been appointed assistant administrator, Ball Memorial Hospital, Muncie, Ind.

John C. Blankenbeckler—has been appointed administrator, Shenandoah Hospital, Roanoke, Va.

Leo Bolin Jr.—has been appointed administrator, Cheyenne County Memorial Hospital, Sidney, Neb., succeeding **Frank Harris**, administrator, Wallace Hospital, Lebanon, Mo. He was formerly business manager, West Nebraska General Hospital, Scottsbluff, Neb.

William H. Botts—has been named administrator, Allen Bennett Memorial Hospital, Greer, S.C., succeeding S. C. Gordon, Jr.

James O. Bremseth—has been named assistant administrator, Marion (Ind.) General Hospital.

Douglas R. Brown—is director, Albany, N.Y. Medical Center Clinics, succeeding **James W. Ryan**, named assistant business manager to succeed **Corbit T. Provost**, who has resigned.

John Buchinsky—has been appointed superintendent, Locust Mountain State Hospital, Shenandoah, Pa.

H. L. Burgin—has been appointed administrator, Los Alamos (N.M.) Medical Center.

James F. Burns—has been elected director, Beekman-Downtown Hospital, New York City.

Donald C. Calcaterra — has been named administrator, New Castle (Ind) State Hospital. He was formerly assistant director, Butterworth Hospital, Grand Rapids, Mich.

Jack K. Cole—has been appointed assistant superintendent, Cincinnati (Ohio) General Hospital. He was formerly assistant administrator, Meriden (Conn.) Hospital.

Robert Cole—has been appointed administrator, Bound Brook (N.J.) Hospital. He was formerly administrator, U. S. Government Hospital, Panama Canal Zone.

Harold O. Conn, M.D.—has been named director, intern and medical education program, Middlesex (Conn.) Memorial Hospital. He was formerly instructor in internal medicine, Yale University School of Medicine, New Haven, Conn.

Virginia Cooke—superintendent, Oregon City (Ore.) Hospital, has retired after 20 years.

Harold M. Coon, M.D.—has been appointed administrator, Milwaukee (Wis.) County Hospital. He was formerly superintendent, University of Wisconsin Hospital, Madison, Wis.

Arthur Crandall—has been named administrator, Grandview Hospital, Edinburg, Tex., succeeding I. Robert Lisbony, who has resigned.

Mrs Amy Crawford—executive housekeeper, Pennsylvania Hospital, Philadelphia, has been elected president, Philadelphia chapter, National Executive Housekeepers' Association.

Jack Culbertson—has been named business manager, Salem (Ore.) General Hospital. He was formerly office manager, Cowlitz General Hospital, Longview, Wash.

Anthony C. Cuty —has been named administrator, New Ohio County Hospital, Hartford, Ky. He was formerly assistant administrator, Payson City (Utah) Hospital.

Neva Davis—has been appointed assistant administrator, Tyler County Hospital, Woodville, Tex.

John Henry Deans—has been named assistant administrator, City Memorial Hospital, Winston-Salem, N.C., succeeding **Charles Frenzel**, who has resigned.

Manuel Delgado—has been appointed administrator, Centro Asturiano Hospital, Tampa, Fla., succeeding **Manuel Rubio, Jr.**

Mrs. Joan Dickerson—has been named director of nursing service, Wood River (Ill.) Township Hospital, succeeding **A. Pearl Smith**, who has resigned. She was formerly a supervisor in the nursing office.

Robert M. Dickson—has been appointed administrator, Stephens Memorial Hospital, Breckenridge, Tex.

Charles V. Dowling, M.D.—has been appointed associate director, medical education program, Baptist Memorial Hospital, Memphis, Tenn.

Mose Ellis—is the new administrator, Sidney R. Forkosh Memorial Hospital, Chicago. He was formerly administrative assistant, Mount Sinai Hospital, Chicago.

V. M. Farrell—has been appointed administrator, San Luis Obispo (Calif.) County Hospital. He was formerly administrative assistant, Dallas (Tex.) County Hospital District.

Wallace W. Favorite—has been appointed administrator, Saline Memorial Hospital, Benton, Ark.

Charles W. Flynn—executive director, Mississippi Hospital Association,

has been appointed executive secretary, Southeastern Hospital Conference.

Robert S. Forhman—has been appointed administrator, Cross County Medical Center, Yonkers, N.Y. He was formerly administrator, Liberty (N. Y.) Maimonides Hospital.

W. B. Forster—has been appointed administrator, Bexar County Hospital System, San Antonio, Tex. He was formerly assistant director, Akron (Ohio) City Hospital. He succeeds Goldman S. Drury.

Wayne Gee—has been named administrator, Hopkins County Memorial Hospital, Sulphur Springs, Tex., succeeding **Bruce Melson,** who has been appointed administrator, Campbell Memorial Hospital, Weatherford, Tex.

Robert C. Gilbert Jr.—has been appointed administrator, Lee County Memorial Hospital, Bishopville, S.C., succeeding **William J. Bishop.**

Philip J. Gillette—has been appointed assistant administrator, University Hospital, University of Washington, Seattle.

Bertha Goodrich—has been named superintendent, Herrin (Ill.) Hospital.

Robert P. Gordon—has been named associate director and business manager, Hermann Hospital, Houston, Tex. He was formerly business manager and assistant director.

Augustine Gunn—has been appointed personnel director, Providence Memorial Hospital, El Paso, Tex.

Mrs. Warren Hagge—has resigned as administrator, Lakefield (Minn.) Municipal Hospital.

Marshall R. Hart—has been appointed chief comptroller, Memorial Hospital, Houston, Tex.

Eugene C. Hawkins—has resigned as administrator, Professional Center Hospital, Montgomery, Ala.

Bethena A. Hilsman, R.N. — has been appointed administrator, Barbour County Hospital, Eufaula, Ala., succeeding **Bert Davidson,** who is administrator, South Florida Baptist Hospital, Plant City. She was formerly administrator, Gordon County Hospital, Calhoun, Ga.

Kenneth Holmquist — has been named superintendent, Bethesda Hospital, St. Paul, Minn., succeeding **L. B. Bensen,** who has retired.

Dave Huffman — administrator, Muskogee (Okla.) General Hospital, has resigned.

Otis Ray Hurst — has been appointed executive director, Texas Hospital Association. He is office manager, Baptist Hospital of Southeast Texas, Beaumont.

Carl Ibach—has resigned as office manager, Vancouver (Wash.) Memorial Hospital.

James H. Irwin — has been appointed administrator, Monmouth (Ill.) Hospital, succeeding **Roy M. Ecker,** who is administrator, Cowlitz General Hospital, Long View, Wash.

C. Lindley Jackson—has been appointed administrator, Brightlook Hospital, St. Johnsbury, Vt. He was formerly administrator, Holden Hospital, Carbondale, Ill.

Frank Jerome — has been appointed administrative assistant, Baton Rouge (La.) General Hospital.

Charles A. Johnson—has resigned as business manager, Martin County Hospital, Stuart, Fla.

Martha L. Johnson — has been named public relations director, St. Francis Hospital, Hartford, Conn.

Raymond Kauoff—has been named assistant administrator, St. Francis Hospital, Breckenridge, Minn.

Herbert Kempf — has been appointed administrator, John Burns Memorial Hospital, Belle Fourche, S.D. He succeeds **Oral Hemry.**

H. W. Kilby—has been appointed administrator, Glynn-Brunswick Memorial Hospital, Brunswick, Ga. He was formerly business manager.

(Continued on next page)

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PHARMACISTS: (a) California. Large hospital, fully approved. $450. (b) 100 bed hospital in college town of about 35,000. (c) South. 125 bed hospital. Complete supervision of pharmacy. (d) Middle West. 100 bed hospital in college town of about 15,000. Some administrative work — purchasing optional. $5400. (e) South. 250 bed hospital affiliated with university. $5000. (f) Chief. 350 bed hospital in city of 250,000. $5760. (g) South. Large teaching hospital. To $5640.

NURSE ADMINISTRATORS: (a) California. 50 bed hospital wants combination Director of Nurses and Administrator. (b) Northwest. New 40 bed hospital in small town close to several large cities. Duties: Head Nurse and Administrator.

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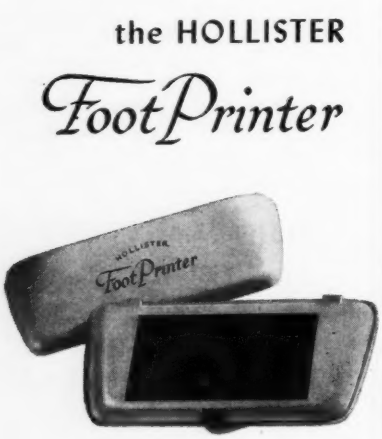

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PERSONALLY SPEAKING Continued

William Knox—administrator, Citizens' Hospital, Lumberton, Miss., has resigned to become a technician, Forrest General Hospital, Hattiesburg, Miss.

Robert J. Koch—Michigan Hospital Service, Detroit, has been named by the National Office Management Association as 1956-1957 national chairman of the Systems and Procedures Committee.

H. Byron Landholt — has been named administrator, Physicians and Surgeons Hospital, Holdenville, Okla. He was formerly administrator, Lawrence County Memorial Hospital, Lawrenceville, Ill.

Jean-Jacques Laurier, M.D.—has been appointed medical director, St. Joseph Hospital, Three Rivers, Quebec, Can.

Robert J. Lawrence—is new assistant director, Muhlenberg Hospital, Plainfield, N.J.

Frances Irene Lay, Lt. Col.—has been appointed Chief, Air Force Nurse Corps, succeeding **Col. Verena Zeller Pettoruto,** who retired. She was formerly assistant chief.

Henry F. Lesem—has retired as administrator, Arizona State Tuberculosis Sanatorium, Tempe.

Richard H. Malone — has been named assistant administrator, Baton Rouge (La.) General Hospital.

H. G. Mann—has been appointed administrator, Henderson County Memorial Hospital, Athens, Tex. succeeding **Mrs. Pauline Eddins Spohn, R.N.**

Robin McGreevy — has been appointed personnel director, St. Vincent's Hospital, Toledo, Ohio.

Rev. Daniel A. McGuire—has been appointed co-administrator, New York Foundling Hospital. He was formerly assistant administrator.

James McLeod—is now administrator, Chillicothe (Mo.) Municipal Hospital. He was formerly administrator, Battenfield-Jones Hospital and Clinic, Snyder, Tex.

Mrs. Elsie McQuay—director of nurses and superintendent, Medical Arts Hospital, Dallas, Tex., has retired after 27 years.

Gordon M. Meade, M.D.—has been appointed clinical director, Miners Memorial Hospital Association, Washington, D.C. Since January he has been chief, clinical services, Williamson Memorial Medical Center.

John W. Moon — administrator, George H. Lanier Memorial Hospital, Langdale, Ala., has resigned to enter Baptist Seminary, Louisville, Ky.

David W. Morgan — has been named administrator, Dow Chemical Hospital, Freeport, Tex. He was formerly administrator, Chilton County Hospital, Clanton, Ala.

Roy A. Morter, M.D.—has retired as medical superintendent, Kalamazoo (Mich.) State Hospital.

John E. Morris — has been appointed administrator, Bamberg (S.C.) County Memorial Hospital, succeeding **E. P. Barnes.**

Howard Lamar Mosley—has been named administrator, Emanuel County Hospital, Swainsboro, Ga., succeeding **James M. Edwards,** who has been appointed administrator, Leeds (Ala.) Hospital.

Mildred F. O'Donnell—is now director of housekeeping services, Alameda County Institutions, Oakland, California.

Robert M. O'Neal, M.D.—has been appointed pathologist, Greenwood (Miss.) Leflore Hospital. He was formerly assistant professor in pathology, Washington University, St. Louis, Mo. and assistant pathologist, Barnes Hospital and St. Louis (Mo.) Children's Hospital.

Floyd D. Parrish — has been appointed assistant administrator, Meriden (Conn.) Hospital, succeeding **Jack Cole.**

Edith D. Payne — has been appointed director, nursing department, Presbyterian-St. Luke's Hospital, Chicago. She was formerly director, school of nursing and nursing service, St. Luke's Hospital, Chicago.

Miriam E. Perry, Col.—has retired as Chief, Air Force Medical Specialist Corps, after 25 years. She is succeeded by **Lt. Col. Audrey A. Underkofler.**

Mrs. Josephine Peterson—administrator, Kewanee (Ill.) Public Hospital, has resigned.

Thomas R. Pettet—has been named administrator, Rockmart-Aragon Hospital, Rockmart, Ga. succeeding **Billy Smith,** who has resigned.

Mrs. Elizabeth Piper — has been appointed director of nurses, Medical

Arts Hospital, Dallas, Tex., succeeding **Mrs. Elsie McQuay,** who has retired.

Howard L. Place—has resigned as administrator, Cheyenne Memorial Hospital, Valley City, N.D., to accept an administrative position at Dunlap Memorial Hospital, Orrville, Ohio.

John L. Proscope — has been named executive director, Mercy-Douglass Hospital, Philadelphia, Pa.

George J. Riesz—has been named administrative assistant, New Mount Sinai Hospital, Toronto, Ontario.

Kenneth Rindflesh—has been named administrator, Ventura (Calif.) County General Hospital succeeding **Lyle Walters.** He was formerly administrator, Salt Lake (Utah) County General Hospital.

Harry J. Rodgers—has retired as superintendent, Memorial Hospital, Philadelphia, Pa.

Milton Sachs—has been appointed assistant superintendent, East Moline (Ill.) State Hospital.

Mrs. Dorothy Sauers—superintendent, Curry General Hospital, Gold Beach, Ore., has resigned because of ill health.

Marian F. Sawyer — has been named administrative assistant, dietary department, Pennsylvania Hospital, Philadelphia.

John T. Scanlon—has been named chief pharmacist and purchasing agent, Babies Hospital, Newark, N.J.

David V. Shaw — has been appointed administrator, New Milford (Conn.) Hospital, succeeding **Mrs. Muriel M. Russell.** He was formerly assistant director, South Side Hospital, Bay Shore, Long Island.

I. Joseph Shyne—has been named administrator, Calumet Memorial Hospital, Chilton, Wis. He was formerly associate administrator, St. Mary's Hospital, Madison, Wis.

Frank Simek—has been appointed assistant administrator, Good Samaritan Hospital, Vincennes, Ind.

Sister Elizabeth Steiner—has been assigned as administrator, St. Mary's Hospital, Evansville, Ind., succeeding **Sister Justina Morgan,** now on the council, Sisters of St. Vincent dePaul, operating organization of the hospital. Sister Elizabeth was formerly medical, surgical and pediatric supervisor, St. Joseph's Hospital, Chicago.

Sister M. Agatha — has been named administrator, St. Clare Hospital, Monroe, Wis., succeeding **Sister M. Bernard.** She was formerly assistant superior and chief accountant.

Sister M. Angelita—has been appointed superior, St. Clare Hospital, Monroe, Wis., succeeding **Sister M. Bernard,** who is returning to St. Agnes Hospital, Fond du Lac, Wis.

Sister M. Cherubim—is now administrator, St. Elizabeth Hospital, Covington, Ky.

Sister M. Dionysia, R.N.—has been appointed administrator, St. John's Hospital, San Angelo, Tex. She was formerly director of nursing service, Santa Rosa Hospital, San Antonio, Tex.

Sister Mary Doris—has been appointed superior and administrator, St. Mary's Hospital, Streator, Ill. succeeding **Sister Lillian.**

Sister M. Gertrudis, O.S.F.—has been named administrator, St. Francis Hospital, Evanston, Ill. She was formerly assistant administrator and director, school of nursing.

Sister M. Jerome, R.N.—has been appointed administrator, St. Andrew's Hospital, Murphysboro, Ill. She was formerly administrator, St. Vincent's Memorial Hospital, Taylorville, Ill.

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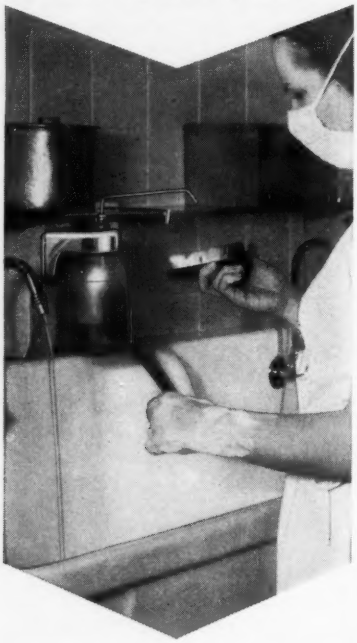

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PERSONALLY SPEAKING Continued

Sister M. Michael, R.S.M., R.N.—has been appointed administrator, Mercy Hospital, Chicago, succeeding **Sister Loretto Marie, R.S.M., R.N.,** who will become a hospital consultant for the Sisters of Mercy. She was formerly director of nursing service.

Sister M. Peregrine—has been appointed administrator, St. Francis Hospital, Peoria, Ill., succeeding **Sister M. Walburga.**

Sister Mary Rosaria—has been appointed administrator, Wheeling (W. Va.) Hospital, succeeding **Sister Mary Thomasina.** She was formerly administrator, St. Mary's Hospital, Clarksburg, W. Va.

Sister Mary Thomasina—has been named director, school of nursing, St. Francis Hospital, Charleston, W. Va. She was formerly administrator, Wheeling (W. Va.) Hospital.

Sister Rose Lethiecq—has been named administrator, St. Vincent's Hospital, Toledo, Ohio, succeeding **Sister Alice Herman.**

Billy Smith—has been appointed superintendent, Tennessee State Penitentiary Hospital, Nashville.

Arthur E. Spillman—assistant superintendent of business services, Metropolitan State Hospital, Norwalk, Calif., has retired.

A. G. Stasel—will resign as administrator, Doctors Memorial Hospital, Minneapolis, Minn., Oct. 1, after 27 years.

Harold W. Steadham—has been appointed administrator, George H. Lanier Memorial Hospital, Langdale, Ala. He was formerly assistant administrator, Baptist Hospital, Pensacola, Fla.

Elmer W. Stocker—has been appointed controller, Greenwich (Conn.) Hospital, succeeding **John J. Dakin** who has been named controller, Austin Riggs Center, Stockbridge, Mass.

Henry Taylor—has been appointed superintendent, Medical Arts Hospital, Dallas, Tex., succeeding **Mrs. Elsie McQuay,** who has retired.

Norman L. Thompson—has been named administrator, French Hospital, San Francisco. He was formerly administrator, Merced (Calif.) County General Hospital.

J. Walter Tosh—has resigned as superintendent, Hazelton (Pa.) State Hospital.

Dan Traner—was elected president, Massachusetts Hospital Association. He is administrator, Lynn (Mass.) Hospital. **Dean A. Clark, M.D.,** general director, Massachusetts General Hospital, Boston was elected president-elect and **Georgie M. Boulter,** administrator, New England Baptist Hospital, Boston was elected treasurer.

Richard Truax—has been appointed personnel director, St. Cloud (Minn.) Hospital.

Hugo Voigt—has been named assistant administrator, Salem (Ore.) Memorial Hospital. He has been business manager, and will continue those duties.

Helen Wainious—has been appointed administrator, VanBuren County Memorial Hospital, Clinton, Ark., succeeding **Naomi Mohr.**

Max B. Wallace—has been appointed administrator, Toronto (Ont.) Western Hospital.

Albert E. Welberry—has been named administrator, Umatilla (Ore.) Hospital, succeeding **Roy Mitchell,** who resigned.

J. D. Westbrook Jr.—has been appointed administrator, Haskell (Tex.) County Hospital.

Albert V. Whitehall—has been named associate director of Health Insurance for the Life Insurance Association of America, New York City.

(Continued on page 61)

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AGENCY

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Mary A. Johnson, Ph.D., Director

Our careful study of position and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefuly evaluated to individual situation, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate, we prefer to keep our listings strictly confidential.

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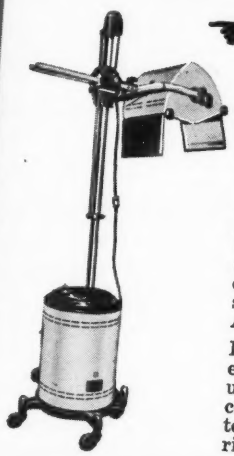

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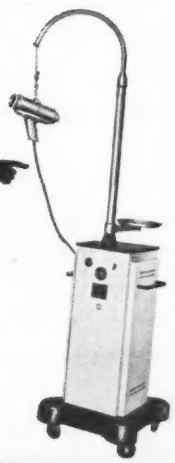

H

Wide Range of Hanovia Ultraviolet Applications Include:

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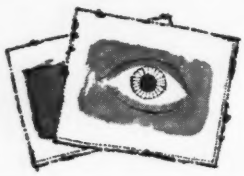
LITERATURE

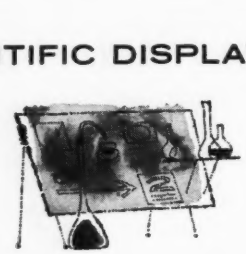
Booklets, brochures and reprints concerning CIBA products will be sent free of charge on request to the Medical Service Department, CIBA, Summit, N. J. In addition, two volumes of particular interest from THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS by Frank H. Netter, M.D.— Vol. 1, *Nervous System* (sold at cost, $6) and Vol. 2, *Reproductive System* (sold at cost, $13)— may be obtained by sending check or money order to Publication Dept., CIBA, Summit, N. J.

ANATOMICAL SLIDES



An extensive library of colored anatomical slides (art work by Frank H. Netter, M.D.) is available for loan or purchase. A complete list of the slides may be obtained by writing the Publication Dept., CIBA, Summit, N. J.

SCIENTIFIC DISPLAYS



The latest scientific information on products manufactured by CIBA is presented in exhibit form for the benefit of staff doctors — without interference with hospital routine. You may write to the Hospital Service Division, CIBA, Summit, N. J., requesting a display on a convenient date.

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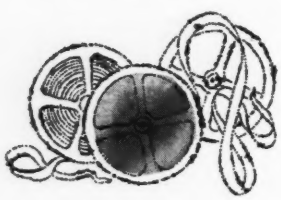

A library of films in color with sound may be borrowed to be used as teaching aids for nurses, residents and internes, or as part of refresher courses and staff meetings. If you wish, projection equipment and a qualified operator will be provided without charge. A list of film titles is available from the Hospital Service Division, CIBA, Summit, N. J.

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C I B A SUMMIT, N.J.

(Continued from page 58)

Formerly he was executive director, Washington Blue Cross, Seattle, Wash.

M. S. White, Brig. Gen., USAF (MC)—has been named director, medical staffing and education for Air Force Medical Service. He was formerly air surgeon, Tactical Air Command, Langley Air Force Base, Va.

Henry J. Whyte—has been appointed administrator, Burrell Memorial Hospital, Roanoke, Va., succeeding **Theodore W. Frazier,** hospital administrator, Florida A & M College. He was formerly administrator, Community Hospital, Wilmington, N. C.

William J. Wicker—has been named administrator, Allendale County Hospital, Fairfax, S. C., succeeding **David P. Willis,** who has been named administrator, Morehead City (N. C.) Hospital.

Fredrick Wickie—has been appointed assistant administrator, Kittson War Veterans Memorial Hospital, Kennedy, Minn.

Delores Wilson—has resigned as superintendent, Garrard County Memorial Hospital, Lancaster, Ky.

Liston A. Witherill—is assistant director, Los Angeles (Calif.) County General Hospital. He was formerly assistant director, Los Angeles County Harbor General Hospital, Torrance, Calif.

Mrs. L. D. Woods—has been named administrator, Waller County Hospital, Hempstead, Tex.

Neil C. Wortley—administrator, Burge Hospital, Springfield, Mo., has resigned to accept a position with Missouri State Health Dept. as hospital administrative consultant.

Marion Wright—is now director, Jennings Memorial Hospital, Detroit, Mich., and was formerly associate director and treasurer, Harper Hospital, Detroit.

Roy Wright, M.D.—has been appointed superintendent, Huey P. Long Charity Hospital, Pineville, La., succeeding **R. E. McGill, M.D.** who has resigned.

George P. Wyman, M.D.—has been appointed director, Milwaukee (Wis.) County Asylum, succeeding **Ernst Schmidhofer,** who has resigned.

Jerome M. Yalon—has been appointed associate administrator, California Medical Center, San Francisco.

VA Nursing Appointments

Ida Brackett—has been appointed assistant chief, nursing service, V.A. Hospital, Fayetteville, N. C.

Jacob Chapman—has been appointed assistant chief, nursing education, VA Hospital, Lebanon, Pa.

Gertrude Cherescavich—is now assistant chief, nursing education, VA Hospital, New York City. She formerly held a similar position, VA Hospital, Cincinnati, Ohio.

Esther Clare—has been named chief, nursing service, VA Hospital,

(Continued on page 87)

How does your present disinfectant compare with O-syl®

Try these yes-or-no questions:	Your present disinfectant	O-syl brand disinfectant
1. Is it **tuberculocidal,** as well as bactericidal and fungicidal?	_____	yes
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3. Will antibacterial action persist against new contaminants as long as a week between applications?	_____	yes
4. Is pre-cleaning unnecessary?	_____	yes
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9. Can it be "standard" for all disinfection needs throughout the hospital?	_____	yes
10. Does a little go a long way so that it is economical* to use?	_____	yes

If you have even one "no" answer, you may want to know more about O-syl. Send for samples and booklet describing its many applications.

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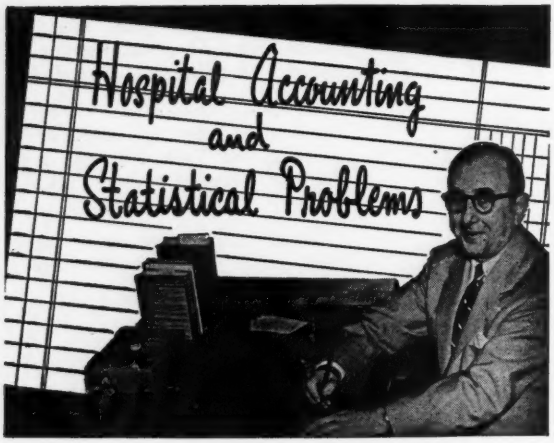

By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. Would you please advise us whether the following individuals are included in the Social Security program and whether we are required to pay the taxes on their salaries or stipends?

a) Student nurses
b) Interns
c) Residents
d) Special nurses
e) Radiologist (bills hospital on percentage basis)

A. a) Student nurses and b) interns: Both of these categories are specifically exempt from the Social Security program. Student nurses may be performing some duties in the hospital, but since they attend regular classes, they are considered *students*, and therefore exempt. In like manner, the intern training program is considered part of the education of the four-year medical school graduate, and interns are therefore exempt from the Social Security program.

c) Residents: This group is not considered in the student category and is therefore included in the Social Security program. House physicians are also included.

d) Special nurses: Special nurses are considered independent of the hospital payroll, since they, in effect, make a contract directly with the patient for payment. As such they are exempt from the hospital's Social Security program. However, they are now included as self-employed persons and must file individual reports annually together with their federal income tax returns.

e) Radiologist: This specialist is not to be included in the hospital's Social Security program, nor is he included in P.L. 880. While this law covered most professions, doctors are still exempt, and do not make provision for this coverage in their individual federal income tax returns.

Q. We do not have an employees' cafeteria in our hospital but serve meals gratis to our employees. In some instances this is for the convenience of the employer, while in others it is not. Does this have a bearing on computing the Social Security taxes due?

A. The fact that meals are served in the hospital, whether for the benefit of the employer or not, does not have a bearing on the tax for Social Security purposes. A valuation *must* be set up for such meals and added to the cash salaries paid in establishing Social Security taxes due.

Q. Occasionally, a sum is deducted from an employee's wages in excess of the total amount (maximum) which is to be reported for a particular year. May such a sum be credited to the employee's account and applied to the next year, or must this sum be paid to the employee in cash?

A. Where one employer withholds too much Social Security tax, the employer should refund the over-collection to the employees within the same calendar year, if possible. However, an over-collection is adjustable between the employer and the employee at any time within the statutory period of limitations upon refunds and credits, provided the adjustment is completed prior to the expiration of the tax return period, following the tax return period in which the error is ascertained by the employer.

An error is ascertained when the employer has sufficient knowledge of the error to be able to correct it. If no adjustment is possible, then the employee may authorize the employer to file a claim and receive a refund or credit of the overpayment, or the employee may file the claim on his own behalf. The form on which this claim must be filed is #843.

Q. When regular employees have exceeded their sick-leave benefits, we deduct from their salaries all time not on duty. In computing withholding taxes for an employee who was absent three days, can you figure the tax to be withheld from the wages paid by deducting two-fifths of the amount of the tax shown in the wage-bracket table for a weekly payroll period, based on the wages the employee would have received had he performed services for the full five-day week?

A. Such a procedure would be incorrect. The salary received by the employee for two days' services represents his wages for that week. For example, the employee in question earns $125 per week and has three exemptions. His normal withholding tax on a full week's pay would be $16. If he worked two days and his gross pay was $50, the employer should deduct $2.20 and not two-fifths of $16, which would be $6.40.

Q. Is it possble for charitable foundations to make distributions to individuals without losing their tax-exempt status?

A. If such grants are made on a *true* charitable basis it would appear that the tax-exempt status of the foundation would not be impaired. The foundation is required to keep adequate records supporting each grant made, which should include the name and address of each recipient, amount paid, relationship between grantor and grantee, etc. We suggest that you refer this question to your board for legal counsel.

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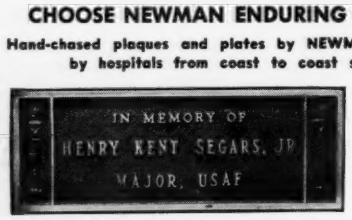
Hand-chased plaques and plates by NEWMAN are preferred by hospitals from coast to coast since 1882.



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economical—1 oz. Zephiran concentrate makes 1 gallon of 1:1000 Zephiran solution.

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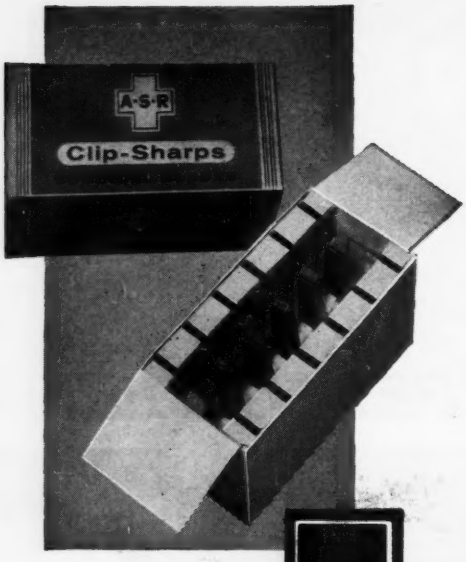

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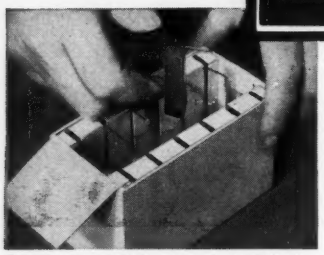
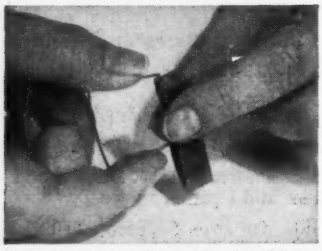
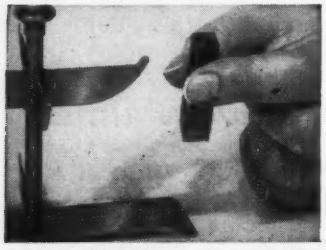
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



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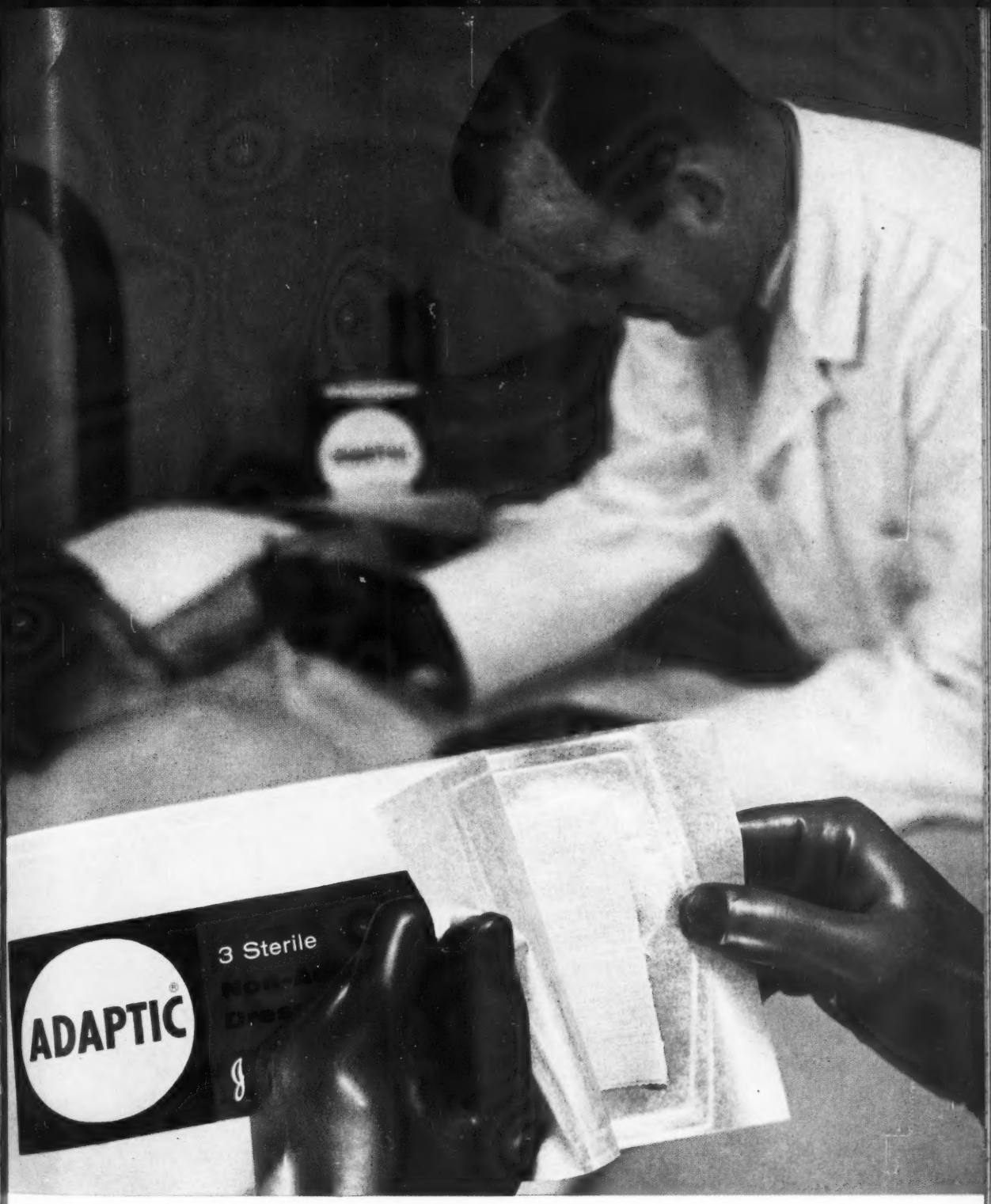

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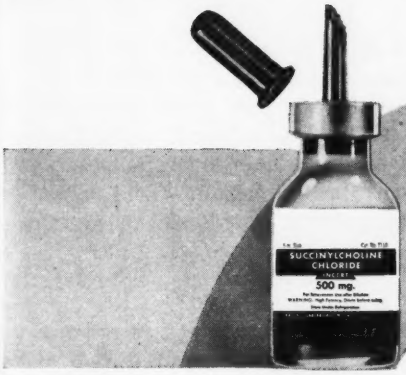

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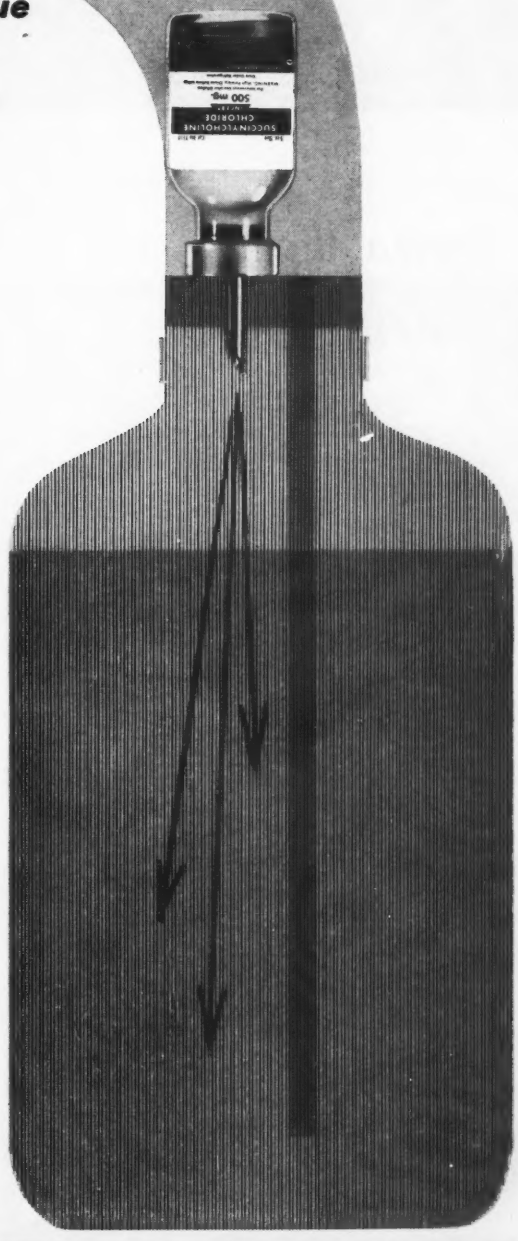

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SUCCINYLCHOLINE CHLORIDE 500 and 1000 mg. in sterile solution

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CALCIUM LEVULINATE (10% solution) 6.5 mEq. Ca^{++} in sterile solution

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Hundreds of booths, thousands of guests, handfuls of samples, innumerable aching feet — all were part of the AHA exhibit hall at the International Amphitheatre, Chicago, where many new items were introduced to the hospital field. Some of them are shown on this and the next nine pages. For more information, please check the Buyer's Guide card opposite page 80.

Down the AHA Aisles With Topics

Foregger's new copper kettle ether vaporizer is shown by salesman George Pickering to Geneva Watkins, head nurse anesthetist, Medical College Hospital, Richmond, Va. Heat is concentrated with a mass of copper, giving the advantage of smooth measured ether. Ether is thoroughly mixed in mixing chamber before delivery to patient. A401.

R. D. Cosgrove, Ohio Chemical, demonstrates portable, easily operated respirator for use in hospitals, clinics, or doctor's offices, to Marguerite Scott, chief nurse anesthetist, Tampa (Fla.) Municipal Hospital. Simple adjustments on the respirator provide any true mouthpiece pressure (negative and positive), which is constantly registered on gauge. For further information, check number A400 on Buyer's Guide card opposite page 80.

John Johns, Rehabilitation Products Division, American Hospital Supply Corp., and Harold Coston, administrator, Cambridge-Maryland Hospital, Cambridge, Md., look over Story Book shoe, an activity board for teaching handicapped children to manipulate door latches or fasteners. A different animal pops out of each door when it is opened. A402.

C. E. Preston, Hill-Rom, tells Al Herron, assistant director, Vanderbilt University Hospital, Nashville, Tenn., and Henry Kidder, assistant director, Aultman Hospital, Canton, O., about the all-electric Hi-low bed (below), which never requires oil or grease. One motor adjusts bed to various heights, and Trendelenburg or Fowler positions. Sections of the bed also move independently. Shown in silver walnut, the bed comes in all fine woods. First delivery of the bed will be in October, 1957. A403.

Above: Sister M. Barbara, administrator, and Sister M. Inelda, bookkeeper, both of St. Francis Hospital, Waterloo, Ia., are shown infant restraining tray by Eugene Rodin, M.D., owner, Ivanhoe Enterprises. Tray gently, firmly, and without pressure holds any baby from 4½ to 10½ lbs. for transfusions, circumcisions, x-rays. A406.

Right: Hosp-I-Tell, new annunciator system, conveys patients' needs to nurse immediately. George H. McLain, vice-president, Multi-Signal Corp., shows W. E. Fales, anesthetist, Columbus Hospital, Chicago, how operation of bedside unit by patient flashes light on installation at nurses' station, showing at a glance what service is requested. Wording imprinted on lights may be easily changed to suit any hospital's requirements. A404.

Alan Hensler, A. S. Aloe, and L. K. Thompson, administrator, Franklin Memorial Hospital, Louisburg, N.C., look over revolving chart file (below), mounted on linoleum-topped steel table. File may be placed between doctors' charting room and nurses' station for use without mutual interference. Comes in 20, 30 or 40-chart capacity. A405.

Ultrasonic cleaner which cleans instruments in 60 seconds was introduced by American Sterilizer at the AHA convention. Shown below are Stanley L. Nelson, chief engineer, Immanuel Hospital, Omaha, Neb., and J. H. Scott, American Sterilizer. Literally millions of submicroscopic reactions cause ledges of soil to collapse into infinitely small particles. Process is wholly safe for even most fragile instruments. A407.

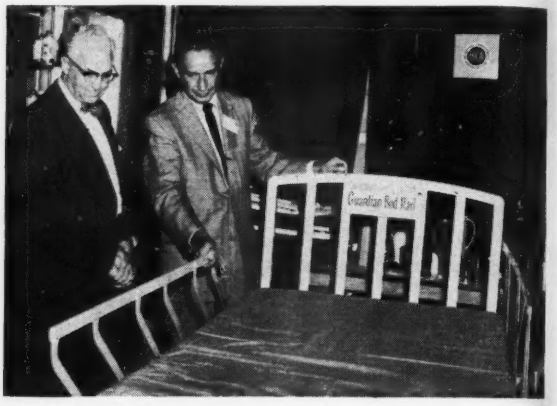
Watching a demonstration of Cole's Carrier (above) by David V. Cole, M.D., and W. Boyd Cole, Cole Mfg. and Medical Supply Co,, (l.) are Verne N. Johnston, Hinsdale (Ill.) Sanitarium and Hospital, and E. Forbes (r.), administrator, Methodist Hospital, Mitchell, S.D. Carrier consists of transfer sheet, carrier, and hoop on which transfer sheet rests. A410.

Down the AHA Aisles

continued

Closed-circuit television is shown by Buford K. Brooks (l.), Hallamore Electronics Corp., to J. Wade Collins, sales manager, American Communications Corp., New York City. Remote Control camera in another location is operated by control-panel unit to right of television set pictured below. Portable system has two-way sound system built in. A408.

Portrayal of a complete, full-scale formula room by Southern Cross Manufacturing Corp. won first place in technical exhibits over 200 square feet. Every hour 500 assemblies were completed — bottle and nipple washing, formula preparation, filling, capping, sterilizing and cooling — demonstrating the latest in flow system technic and equipment A409.



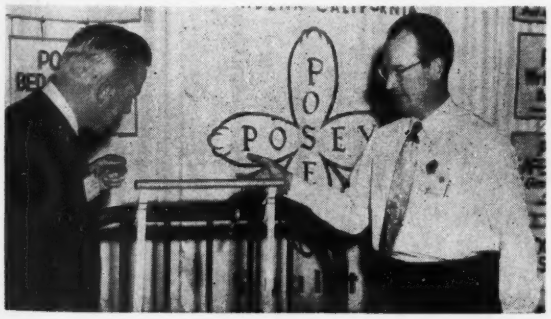
Above: Harry C. Rose, president, Correy Distributors, demonstrates "Guardian" bed rail to B. W. Mandelstam, M.D., administrator, Mount Sinai Hospital, Minneapolis, Minn. Collapsible and easy to operate, rails also eliminate bed and wall damage, and cannot be removed by patient. A411.

Hydraulically operated minor surgery table for eye, ear, nose and throat surgery, or emergency room use, is easily adjustable to required positions, as E. B. Stephens, Ritter Co., explains to Robert F. Scates, assistant administrator, Baptist Memorial Hospital, Memphis, Tenn., and Edwin B. Peel, administrator, Georgia Baptist Hospital, Atlanta. A412.

Below: Herbert Buchanan, anesthetist, 90th Tactical Hospital, Topeka, Kan., examines automatic blood pressure recorder shown by Mel Martins, Colson Corp. Systolic and diastolic pressure is measured at intervals of from 30 seconds to one hour and registered on chart. Warning device summons assistance when pressure reaches pre-set critical level. A413.

Transaver patient handler below consists of litter, shuttler on which litter rests for ambulance transport, and straddler on which litter is moved from place to place in hospital. Legs of straddler lock in solid line for transport, swing around to straddle examining, x-ray, or operating table. Left to right: C. McCarthy, Picker X-Ray; Gene Kidd, administrator, and Jack Massey, president of board, Baptist Hospital, Nashville, Tenn. A1414.

Donald E. Wood, executive secretary, Association of Twin City Hospitals, Minneapolis-St. Paul, is shown "patient helper" (below) by J. T. Posey, president, J. T. Posey Co. "Patient helper" provides means for patient to pull himself up out of bed, and is always available, yet is out of the way. A415.



Above: Art Krail, Surgical Products Division, American Cyanamid Co., shows Dermalon mesh to Ed Herring, medical and surgical instructor, Anne A. Stachiak, R.N., and Ann K. Mohr, R.N., clinical instructor, all of St. Anthony de Padua Hospital, Chicago. Dermalon nylon mesh is used for reconstructive and plastic surgery. A416.

Below: Revlon representative Jeanne Stange shows Baby Silicare to Russell T. Clayton and Charles R. Sanders, Northwestern University School of Hospital Administration students, Chicago. Ingredients in Baby Silicare have been formulated to combat and treat diaper rash. It comes in 5 and 10-oz. hospital sizes. A417.

Below: Mrs. Harry Himmel, chairman, and Mrs. Susan L. Waddell, manager, women's board restaurant, Michael Reese Hospital, Chicago, look over new postoperative stretcher with R. W. Westerfield, Jarvis & Jarvis. Three-way mechanism elevates entire litter or either end independently. Sponge-rubber shoulder rests prevent patient from sliding backward. A418.

Down the AHA Aisles

continued

George Demain (l.) and Christian J. McCaffey (r.), administrator, Royal Newcastle Hospital, Newcastle, Australia, discuss syringe sterilizer bags (below) put out by George Demain & Co. Bull's eye on bag turns brown when autoclaved. A419.

Below: Pharmaseal representative R. R. Meredith shows Reuben C. Anderson, president of board, Bethesda Hospital, St. Paul, Minn., the money-saving disposable enema. A420.

Below: Joseph Kronish, president, The Hospital Supply Co., and Rogers W. Higgins, Allen Clinic, Orlando, Fla., examine electric steam generator. Enclosed in stainless steel cabinet, it delivers steam instantaneously at adjustable pressures. A421.

THE HOSPITAL SUPPLY COMPANY, INC.
INSTANTANEOUS / ELECTRIC STEAM GENERATOR
Sterilizers Stills Steam Cookers
and any equipment requiring steam

Above: Walter W. Lane, Iowa Department of Health, Des Moines, stopped in at the Vestal booth to hear E. S. Ordelheide tell him about Vesphene. In Vesphene, heavy-duty cleaners and germicidal agents have been combined to produce an efficient cleaner and germicide in one concentration. A422.

Above: W. L. Williams, Air-Shields, Inc., tells Irene E. Oliver, administrator, Magic Valley Memorial Hospital, Twin Falls, Ida., about mobile open-air mist apparatus with controlled high humidity, for use by adults in recovery room. A423.

Above: Mrs. Joseph Glaser and Mrs. L. Kurtz, auxiliary, General Rose Memorial Hospital, Denver, Colo., examine Kotex maternity pad and four cotton balls for postpartum care, now available in a single package. Arthur Hammond, Bauer and Black, points out that prepack eliminates counting, wrapping and labeling. A424.

Above: L. W. Malin, M.D., administrator, Eugene Leland Memorial Hospital, Riverdale, Md., and Mrs. Malin (l.) watch as Mrs. Helen Metcalfe, Hausted Mfg. Co., operates invalid chair. Chair cranks from wheel chair to horizontal position for use as a litter. It is chrome-plated with leather-covered foam-rubber padding. A425.

Below: William L. Wilson, administrator, Mary Hitchcock Memorial Hospital, Hanover, N. H., manipulates new separate filter-

pressure system as Tom Mulle, Mead Johnson, looks on. Pressure unit is separate from and below drip and filter chamber, so that pressure cannot be applied to unfiltered blood. A426.

Gail Grosvenor shows "Papa Poochie" to Alma O. Becker (l.), Kansas City, Mo., in the Tykie Toy booth (below). Tykie stuffed toys are filled with latex foam rubber for easy laundering and quick drying. A427.

Above: Mrs. Russell W. Krapp, Ar-Kay Industries, and Sister Rosalia, general supervisor, Braddock (Pa.) General Hospital, are shown in front of a Halsey panoramic mobile illuminator bank. Illuminators can be tilted to any angle by loosening knobs on stand pivot. A428.

Marian Curtis, administrator, and William H. Walter, assistant administrator, Syracuse (N. Y.) Memorial Hospital, discuss the Bucksco "Early Bird" coffee cart (above) with Ron D. Hillis, Bucks County Enterprises. Constructed of aircraft aluminum alloy, cart is light and easy to handle, quiet in operation. A429.

Surgical dispenser of stainless steel and glass is shown by Bert Flint, Huntington Laboratories, to Helen Spry, nurse anesthetist, Edgewater Hospital, Chicago. Operated by a foot pedal, dispenser can be disassembled and autoclaved quickly and easily. A430.

Down the AHA Aisles

continued

Above: Art Hanson, Dukane Corp., demonstrates multiple-channel nurses' call system to Joanna A. Henry, assistant administrator, Woman's Hospital, Detroit. System permits use of a second nurses' master station. Separate calls can be answered from either master station simultaneously. A431.

Above: G. W. Baxter, Zimmer Mfg. Co., shows how toggle clamps on Zimmer octagon aluminum frame make it easier to fasten frame to bed. Watching him are Howard Forbes, oxygen therapist, and Karen J. Gosling, student nurse, both of South Chicago Community Hospital, Chicago. With toggle clamps, which fit all types of beds, less time is needed to set up and dismantle frame. A432.

Below: Sister Alexander Mary, treasurer, and Sister Mary Paulina, floor supervisor, St. Francis Hospital, Blue Island, Ill., are shown croup tent by James J. Bowden, OEM Corp. Tent straps to head of bed, mattress guard, or spring, and remains in position even when bed is raised. It provides properly cooled atmosphere for administration of supersaturated high humidity or aerosols. A433.

Above: Barbara C. Stevenson (l.), publicity chairman, Santa Fe (N. M.) Indian Hospital auxiliary, feels the edge of a disposable bassinet for newborn infant. Marion Martin, Chuck-A-Bed Corp., explains that bassinets are made of strong corrugated board and constructed in one piece. Delivered flat, bassinet can be assembled in a moment. There is also space for baby's name and vital information on one end. A434.

Above: Arthur P. Whiteway, Marsales Co., holds in the palm of his hand the Spartan sponge for Mrs. Olin W. Rogers, anesthetist, Ft. Sanders Presbyterian Hospital, Knoxville, Tenn., to see. This postoperative sponge, which the manufacturer says is more economical than cotton-filamented sponges, is a combination of cotton and cellulose, with eight plys of gauze. A435.

Above: George Rosselle (center), Gilbert Hyde Chick Co., shows infant's operating table to John R. Shepard (l.), manager of business office, and Charles C. Ingersoll (r.), assistant superintendent, both of University of Iowa Hospitals, Iowa City. The first complete infant's operating table introduced to the hospital field, it is now going into production. A436.

Below: Jerry White of ABCO Dealers, Inc., tells Philip Calandrino, hospital architect, Department of Public Health, Bureau of Hospitals, Springfield, Ill., about the Barron food pump. It provides the first satisfactorily controlled method of alimentary ingestion of natural foods in patients unable to accept whole foods. A437.

Below: Arthur J. Redland, M.D., commanding officer and administrator, Murphy Army Hospital, Waltham, Mass., learns about Dermassage from Mark H. Baskin, S. M. Edison Chemical Co. Dermassage is a creamy emollient body rub for cooling and lubricating skin and combatting surface infections. A438.

Below: S. Blickman food conveyor transports 18, 20, 22, or 24 complete servings of hot and cold foods, as well as beverages, trays, dishes, and flatware. Left to right: Leland J. Mamer, administrator, St. Luke's Hospital, New York City: V. N. Antonell, S. Blickman; T. Joseph Hogan, branch chief, construction and maintenance, Bureau of Medical Services, USPHS, Washington, D.C.; T. Anker, S. Blickman. A439.

Above: George W. Haag, Merck-Sharp & Dohme, tells Harold A. Devine (r.), pharmacist, Augustana Hospital, Chicago, about Cathomycin, new antibacterial which has been clinically proved highly effective against numerous strains of staphylococci resistant to other antibiotics. A440.

Above: Sister Mary Agnes, administrator, St. Joseph's Hospital, Oakes, N.D., examines mobile Labline power scrub for cleaning laboratory glassware. Alexander I. Newman of Chicago Surgical and Electrical Co. is at left. Power scrub reduces breakage, speeds up washing, cleans glassware film-free. A441.

Above: F. Nerad, Professional Tape Co., demonstrates tape dispenser with self-cutting edge to Barbara Work, Buyer's Guide editor. Time self-sticking labels eliminate licking. Vinyl-coated, they can be frozen or boiled, and marked with pen, pencil, or typewriter. Choice of 500 labels. A442.

Down the AHA Aisles

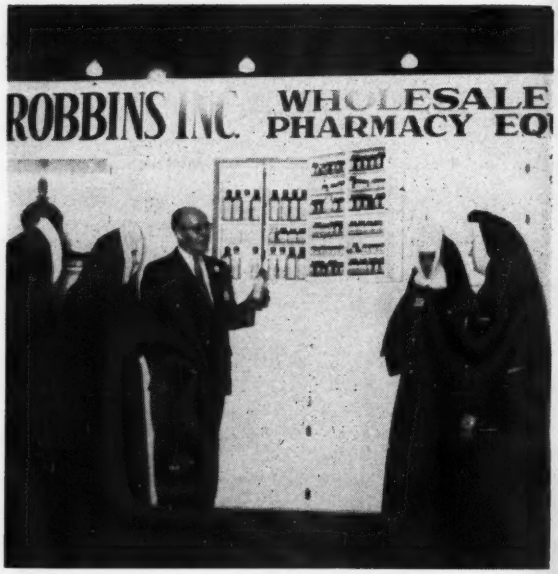
continued

Above: Allan Campbell, Glasco Products Co., shows sundry jar set to Bert P. Sherman, Commodity Standards Section, USPHS, Washington, D.C. Set of five glass jars for physician's use comes in stainless steel, white, pink or blue lids and rack. A443.

Above: Julius Bienstock of The John Bunn Corp. tells John R. Walker (l.), executive secretary, Utah Hospital Association, and Kenneth E. Knapp, administrator, Thomas D. Dee Memorial Hospital, Ogden, Utah, about portable ultrasonic cleaner for instruments, needles, and syringes. The scrubbing action comes from changing electrical energy into sound waves. A444.

Right: FolDoor fabric-covered folding doors are displayed by M. Stuart Cavell, C. A. Potts, and W. A. Laurent, all of Holcomb and Hoke Mfg. Co. A445.

Above: C. R. Jungkind, Becton, Dickinson & Co., shows plastic container for used needles to Oscar Hilliard, administrator, Tri-County Hospital, Ft. Oglethorpe, Ga. Container holds 48 needles. A446.



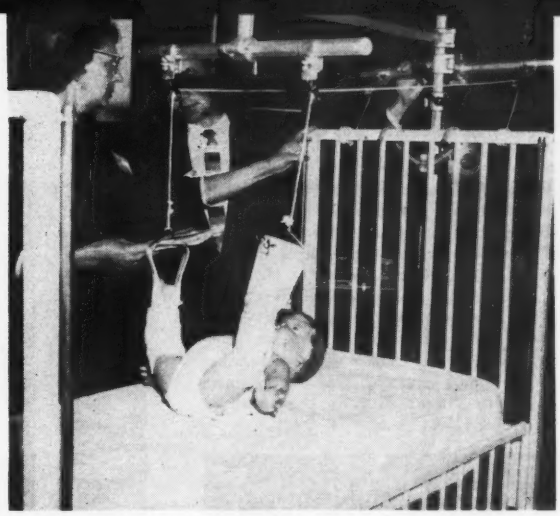
Above: Sister Mary Angeline, Mercy Hospital, Springfield, Mass., Sister M. Bernardine, St. Vincent Hospital, Worcester, Mass., Sister Mary Magdalen, St. Luke's Hospital, Pittsfield, Mass., and Sister M. Augustine, St. Joseph Hospital, Bangor, Me., all anesthetists, stand before pharmaceutical storage unit with Ralph Ryner, McKesson & Robbins, Inc. One 2-foot unit contains storage capacity of 12 feet of straight shelving. A447.

Above: Edward W. Horgen, administrator, King's Daughters' Hospital, Ashland, Ky., listens to cardiac monitor through earphone as Warren G. Armstrong, E & J, describes the battery-operated, explosion-proof meter for visual or aural monitoring of electrical output of heart. Model is Lois Nelson. A448.

Bates Fabrics, Inc., has introduced a Noplete blanket in vat-dyed green especially for hospital use. Ideal as a light cover, warm sheet, or ether blanket, it is available in sizes 68"x90", 68"x99", and 68"x108". A449.

Above: Mrs. Clifford Browne, president, Burge Hospital auxiliary, Springfield, Mo., feels latex foam cushion held by Albert Rowland, B. F. Goodrich. Mrs. Frank Ritzen, vice-president of the Burge auxiliary, is at left. Tough one-piece construction of cushion makes it rugged enough to withstand repeated sterilizations. A450.

Right: W. B. Borsdorff (center), Johnson & Johnson, shows prewrapped dressings ready for sterilization to A. Preston Nisbet (l), administrator, and Ashley H. Gale, assistant administrator, Self Memorial Hospital, Greenwood, S.C. Items in the first such line to be offered include Modess super-pad; "Adaptic"; J-D Pak; and Topper sponges. A451.



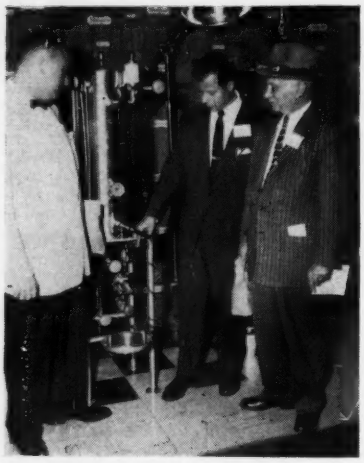
J. K. Landis (above), DePuy Mfg. Co., points out features of crib fracture set to Ann Bland, hospital consultant, Florida Development Commission, Tallahassee, Fla. Eighteen-pound set, constructed of octagonal aluminum alloy tubing, attaches to any metal or wood crib, for all types of traction for infants and children. A452.

Above: Shirley Schabloske (l.) and Betty Hough (r.), graduate nurses at St. Bernard's Hospital, Chicago, try out double student's desk. Made of solid birch, desk has three drawers on each side. P. E. Best, Eichenlaubs salesman, points out other features of desk. A453.

Down the AHA Aisles

continued

Below: A. George Skaller (center), general manager, Shampaine Electric Co., demonstrates automatic water sterilizer for Milton Margoles, M.D., medical director, anl Harry Roseman, board of directors, Capitol Hospital, Milwaukee, Wis. Unit dispenses sterile water at all times at selective temperature. Single-tank construction does work of conventional hot and cold pair of tanks. Available in steam or electric, 15 or 25 gallons, exposed or recessed. A454.



One drop of Nilodor concentrated deodorizer is said to be enough to deodorize a room, effective for 24 hours. No mixing or diluting necessary. Institutional Products Corp. A455.

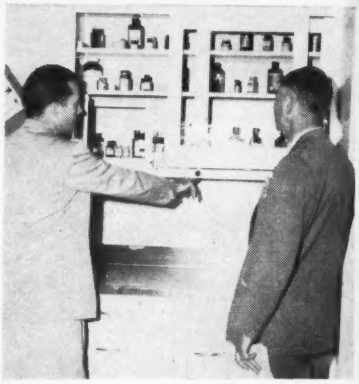
Below: M. G. McBane, Wilmot Castle, explains features of new automatic gas sterilizer to A. J. Wiese, USPHS Hospital, Chicago, and Thomas C. Thompson, ECA/U.S. Operations Mission, Rio de Janeiro, Brazil. Sterilizer uses cold gas for positive sterilization of those materials susceptible to heat of steam, according to manufacturer. A456.

Above: Liquid oxygen cylinder holds 3,000 cubic feet of oxygen, yet weighs only 505 lbs. when full, as J. A. House, Linde Air Products, points out to Carl A. Erikson, Jr., Chicago architect. No special preparation is needed to put cylinder into operation. A457.

Above: Rudolph Anthony (r.), Pfizer Laboratories, shows Steraject cartridge to G. Clare Bishop, administrator, Bishop Hospital, Almont, Mich. Cartridge containing single dose antibiotic formulation, with sterile needle affixed, is used with unbreakable Steraject syringe. Empty cartridge and needle are discarded; syringe may be re-used without sterilization. A458.

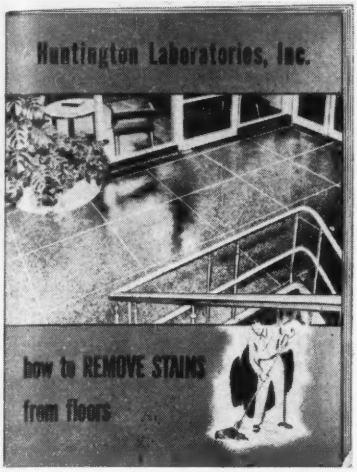
Right: Russell Ladd, McKesson Appliance Co., shows M. A. Baranowski, anesthetist, Woodward General Hospital, Detroit, how to operate portable emergency oxygen and resuscitation unit. Weight of stand and valve is 5¼ lbs. A459.

Above: Sister M. Cleta, operating room supervisor, St. Elizabeth Hospital, Granite City, Ill., examines Story dissecting forceps. John Rozboril, Edward Weck & Co., is at right.



Above: R. J. Rodgers, St. Charles Mfg. Co., points out lock on narcotics cabinet to S. W. Morrison, director of pharmacy, Chicago Wesley Memorial Hospital. St. Charles casework units, of furniture steel, are made to order. A461.

430. Floor stain removal



Booklet gives first steps for general stain and spot removal from all floors. Specific instructions are given for soft and hard floors, and for removing 14 problem stains from hard floors. Huntington Laboratories, Inc.

431. Respiration brochure

Contains descriptive information, sketches, charts, and diagrams explaining normal respiration and illustrating the action of several artificial respirators. Included is a glossary of technical terms used in connection with respiration. Conitech, Ltd.

432. Anesthesia apparatus

Two-color, 44-page catalog describes fully and gives prices of complete line of anesthesia apparatus and accessories. Ohio Chemical & Surgical Equipment Co.

433. Freeze-drying brochure

Seven types of dryers in all price ranges are described and illustrated, with 50 accessories. Included with brochure is leaflet describing the Cryptovaporator, a self-contained unit serving as general freeze dryer, desiccator, and tray dryer. E. Machlett & Son.

434. Blood pipette

Bulletin explains new blood pipette for performing six routine hematologic studies on one sample of capillary blood. Delmar Scientific Laboratories.

435. Outline of analytical procedure

New method for the determination of sodium and potassium in blood serum or plasma, with flame photometer, is given in this bulletin. Procedure requires only a single dilution of serum or plasma sample, and a single standardizing solution. Coleman Instruments, Inc.

436. Burette attachment

Use of Natelson Microgasometer as a Micro-Burette with Burette attachment is described in this leaflet. Scientific Industries, Inc.

437. Oxygen therapy film

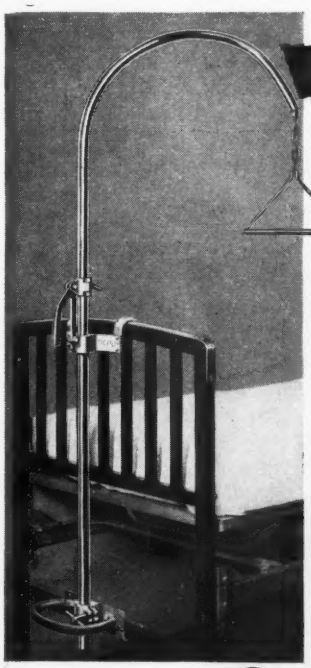
Colored educational filmstrip deals with the physiological basis for oxygen therapy in treatment of diseases of heart and lungs. Booklet contains synopsis of film. Ohio Chemical & Surgical Equipment Co.

438. Film on reagents

"Precision Tools in Bottles" is a 10-minute color film dealing with the theme that reagent-grade chemicals are precision tools. Fisher Scientific Co.

439. Portion control guide

Brochure describes and illustrates beef, lamb, veal, and pork in portion control; also portion control oven-ready roasts. Shows yields realized from "do it yourself" methods. Pfaelzer Brothers, Inc.



IMPROVED PATIENT HELPER
by DePuy

This unit combines the popular goose-neck style patient helper with our exclusive lock-lever bed clamps. One nurse can attach the Improved Patient Helper in rigid position to practically any style hospital bed in a few moments. The rubber padded clamps attach to any head or foot portion of bed . . . no corner post attachment. Goose-neck fits down into supporting tube for greater strength. All tubing nickel plated electric welded steel. Trapeze portion swings free . . . can be swung out of way when not in use. A valuable patient aid . . . helps patient help himself! No. 670, $37.50

NEW WALL PROTECTOR

Prevents clamps of the Improved Patient Helper, Featherwight Overhead Frame, or Crib Fracture Set from damaging walls. Rubber covered steel. Easily attached to any of the above units. No. 675, $3.00

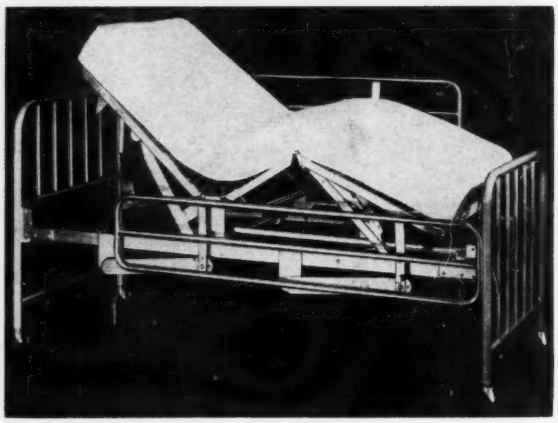
DePuy MANUFACTURING CO., INC.
Since 1895 Standard of Quality
WARSAW • INDIANA

BUYER'S GUIDE

Barbara Work
Buyer's Guide Editor

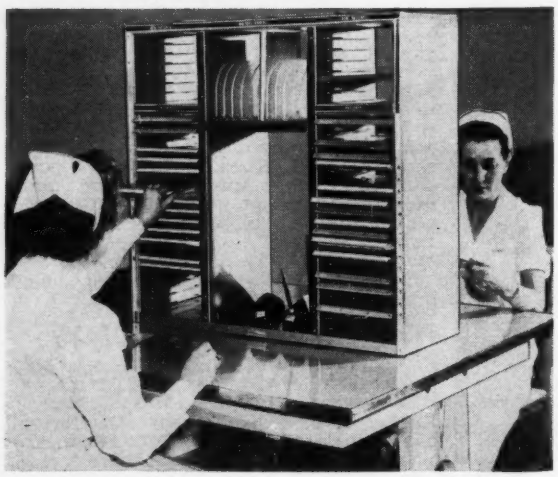
For further information on any of the products, please check the Buyer's Guide number on the reply card facing page 80.

400. Safety side



Pivoting arms lock securely when side is swung into raised position. When lowered, side is flush with spring, facilitating patient care and bed-making. By releasing two catches, sides can be removed in 10 seconds and easily transferred from one bed to another. Sets, including sides, arms, cross-rods and four brackets, fit standard or short beds without overhang when lowered. New Universal safety side is available in chrome finish or enamel. Royal Metal Mfg. Co.

401. File system

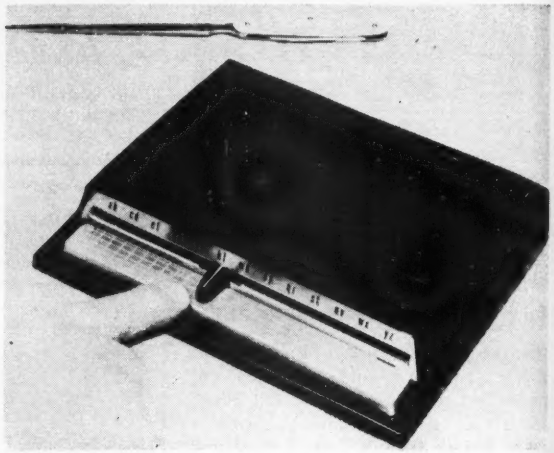


Boone two-way chart file system may be used from either side when placed on a desk, or built into a wall between two rooms. Four persons can work simultaneously, two on each side. Charts are separated into three categories: new patient, active, and doctor's orders. Identification strips at both ends of chart holder. Rack is available in either 30 or 40-chart capacity. Shampaine Co.

402. Enema tube

An exclusive feature of the new disposable enema tube is the "turn-valve cap," which seals off the contents of the tube until the patient is made ready. It also allows critical adjustment from closed to desired rate of flow. Cutter Laboratories.

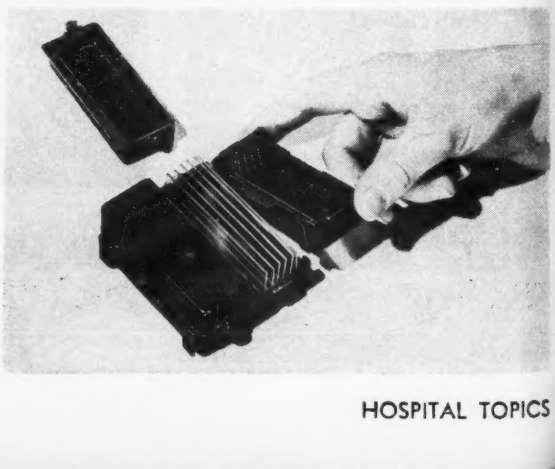
403. Magnetic index



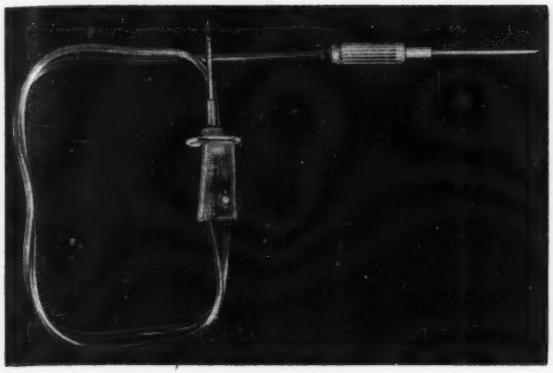
Desk telephone index uses a powerful magnet as a lifting and holding device. A slight pressure on the metal release bar snaps open the index to the correct section. Top stands up for fast reading, snaps back and lies flat for easy writing. Index cards can be inserted in a typewriter. Cory Corp.

404. Slide boxes

Add-a-Box slide boxes allow technician to store as many slides as he needs in minimum amount of space. Each slide box holds six 3" x 1" micro slides. Boxes lock together on either side, easily and simply, with slip-lock joints. Made of heat-resistant black plastic with snap cover. American Hospital Supply Corp.



405. Blood-donor set

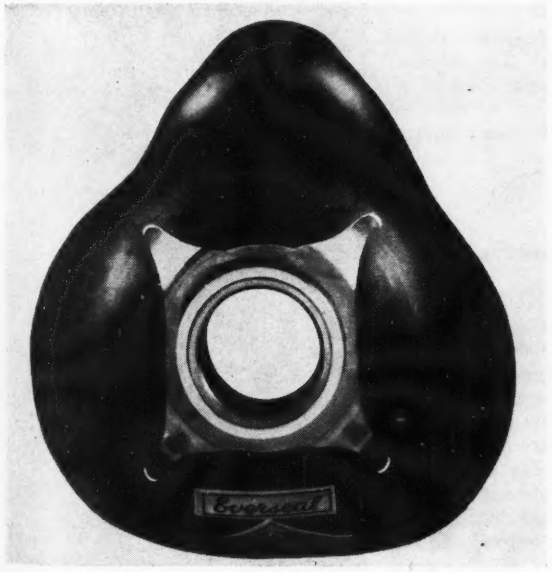


New disposable donor set for vacuum bottle collection permits complete control of blood flow rate between donor and bottle. Made of clear styrene, sets help reduce hemolysis and vein collapse. Valve in grip of bottle puncture needle adjusts with simple thumb movement to accommodate variations in vacuum bottle's suction; shuts off completely without special clamps. Sterilon Corp.

406. Automatic doors

"Magic Door," controls save manpower by speeding traffic flow throughout hospital, prevent patient and employee inconvenience, and eliminate damage to dishes, drugs, doors, and carts. Controls fit any swinging or sliding door, are easily installed, and are easy and inexpensive to maintain. Controls include magic eye, magic carpet, wall plate, and floor switch. The Stanley Works.

407. Face mask



Antistatic face mask, of durable, heavy-gauge rubber, has non-detachable metal adapters yet it is completely pliable. For use with Heidbrink and Foregger machines, it comes in four sizes. Mask has longer life, according to manufacturer, because of its flap-type construction, with no inflatable cushions to accelerate deterioration. Positive fit prevents leakage. Anesco.

408. High protein cereal

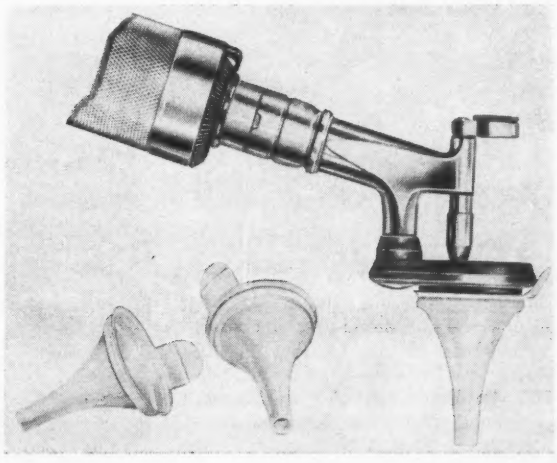
Fifth member of the Pablum cereal family contains 35 percent protein. Three ounces of the new high-protein cereal will supply the full daily requirements for growing children, according to researchers. Available in 8-oz. packages. Mead Johnson & Co.

409. In-Bed scale

Bedridden patients can be weighed without being removed from their beds. The scale may also be used to weigh standing or sitting ambulatory patients. Simple to operate, the In-Bed scale is easily wheeled by one person, takes up less than 2′ x 3′ of floor space, adjusts to various bed heights, and requires no lifting of the patient. In-bed weighings can be made in less than three minutes. Acme Scale Co.

410. Otoscope specula

Disposable otoscope specula permit doctor to use a speculum once, discard it, and replace it instantly with a fresh one. Danger of cross-infection is minimized and necessity of sterilizing specula eliminated, manufacturer says. Disposable specula are made of a specially developed, white, chemically resistant plastic, and are packed in tubes holding 40 "specs." Welch Allyn, Inc.



BUYER'S GUIDE

Continued

411. Adhesive tape

New surgical adhesive tape stays fresh, unwinds easily. High tensile strength makes it adequate for any use. No delamination and no gummy mass left on skin. Bauer & Black.

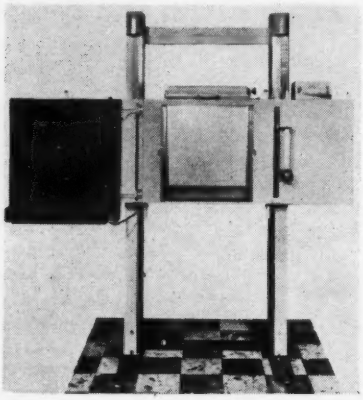
412. Tincture of Benzoin

Tincture of Benzoin protects skin before taping or bandaging, increases adhesiveness of tape to skin. Aerosol dispenser allows one-hand application and eliminates need for applicators or sponges. American Hospital Supply Corp.

413. Drinking fountains

Vitreous china fountains have been modified and re-designed to meet hospital requirements and provide maximum protection against contamination. Models are wall-hung, recessed and pedestal, high and lowback, and with one, two or three angle-stream bubblers. American-Standard.

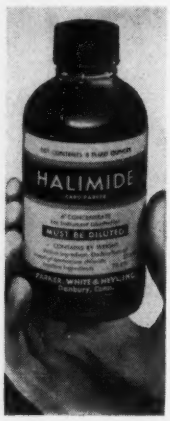
414. Cassette changer



Motor-driven cassette changer shifts cassettes in less than 1.5 seconds. Accepts any size cassette from 8" x 10" to 14" x 17", either vertical or horizontal. Neon lights locate hidden cassette. Westinghouse.

415. New concentrate

Halimide is a concentrate of low surface tension and excellent penetrating qualities for instrument disinfection. According to the manufacturer, it is rapidly bactericidal, nonselective, and tuberculocidal when diluted with alcohol. It is also noncorrosive and does not need to be changed frequently. Bard-Parker Co., Inc.



416. Sterilclave

Stainless steel, dry-heat Sterilclave is furnished with two individual instrument trays and an insulated tray removal handle. Thermostat on top of unit controls temperature. Walls and legs are fully insulated. D. A. Kadan Co., Inc.

417. Floor machine

Engineered for rugged maintenance duty in places having very large floor areas, this machine scrubs, shampoos, waxes, polishes, grinds, sands, buffs, or dry-cleans. For use on all types of floor surfacing, including carpeting. Premier Co.

BUYER'S GUIDE Information Service

400. Safety side
401. File system
402. Enema tube
403. Magnetic index
404. Slide boxes
405. Blood donor set
406. Automatic doors
407. Face mask
408. High protein cereal
409. In-Bed scale
410. Otoscope specula
411. Adhesive tape
412. Tincture of Benzoin
413. Drinking fountains
414. Cassette changer
415. New concentrate
416. Sterilclave
417. Floor machine

DOWN THE AHA AISLES

A400. Portable respirator
A401. Ether vaporizer
A402. Story Book shoe
A403. Hi-low bed
A404. Annunciator system
A405. Chart file
A406. Restraining tray
A407. Instrument cleaner
A408. Closed circuit TV
A409. Formula room
A410. Patient carrier
A411. Bed rail
A412. Minor surgery table
A413. Blood pressure recorder
A414. Patient handler
A415. Patient helper
A416. Nylon mesh
A417. Baby Silicare
A418. Postoperative stretcher
A419. Autoclave bags
A420. Disposable enema
A421. Steam generator
A422. Cleaner-germicide
A423. Mist apparatus
A424. Pre-pack
A425. Invalid chair
A426. Filter pressure system
A427. Tykie toys
A428. Illuminator bank
A429. Coffee cart
A430. Surgical dispenser
A431. Nurses' call system
A432. Octagon aluminum frame
A433. Croup tent
A434. Disposable bassinet
A435. Postoperative sponge
A436. Infant operating table
A437. Food pump
A438. Body rub
A439. Food conveyor
A440. Antibacterial
A441. Power scrub
A442. Labels
A443. Sundry jar set
A444. Portable ultrasonic cleaner
A445. Folding doors
A446. Needle container
A447. Pharmaceutical storage
A448. Cardiac monitor
A449. Hospital blanket
A450. Foam cushion
A451. Pre-wrapped dressings
A452. Crib fracture set
A453. Student's desk
A454. Water sterilizer
A455. Deodorizer
A456. Gas sterilizer
A457. Oxygen cylinder
A458. Steraject
A459. Emergency oxygen unit
A460. Dissecting forceps
A461. Casework

NEW LITERATURE

430. Floor stain removal
431. Respiration brochure
432. Anesthesia apparatus
433. Freeze-drying brochure
434. Blood pipette
435. Analytical procedure
436. Burette attachment
437. Oxygen therapy film
438. Film on reagents
439. Portion control guide

FOLDERS

440. Aeroplast Corp.
441. Air-Shields, Inc.
442. A. S. Aloe Co.
443. American Sterilizer
444. Wilmot Castle Co.
445. CIBA

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447. Hanovia Chemical & Mfg. Co.
448. Hill-Rom Co.
449. Macalaster Bicknell
450. Meinecke & Co.
451. Mead Johnson & Co.
452. Newman Brothers, Inc.
453. Orthopedic Equipment Co.
454. George P. Pilling & Son
455. West Disinfecting Co.

FREE SAMPLES

460. Aseptic-Thermo Indicator Co.
461. Crescent Surgical Sales Co.
462. J. A. Deknatel & Son
463. Flex-Straw Co.
464. Franklin C. Hollister Co.
465. Professional Tape Co.
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400	409	A400	A409	A418	A427	A436	A445	A454	431	440	449	462
401	410	A401	A410	A419	A428	A437	A446	A455	432	441	450	463
402	411	A402	A411	A420	A429	A438	A447	A456	433	442	451	464
403	412	A403	A412	A421	A430	A439	A448	A457	434	443	452	465
404	413	A404	A413	A422	A431	A440	A449	A458	435	444	453	466
405	414	A405	A414	A423	A432	A441	A450	A459	436	445	454	
406	415	A406	A415	A424	A433	A442	A451	A460	437	446	455	
407	416	A407	A416	A425	A434	A443	A452	A461	438	447	460	
408	417	A408	A417	A426	A435	A444	A453	430	439	448	461	

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(Please Print)

Hospital .....

Address .....

City .....Zone .....State .....

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Hospital .....

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City .....Zone .....State .....

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Pediatrics

Caring for the Hospitalized Child

By Delbert L. Price, B.S.C., M.B.A., F.A.C.H.A.*

• There are many factors involved in the hospitalization of a child which go considerably beyond the services required for a hospitalized adult. It is no wonder, therefore, that the cost of pediatric care is considerably higher. Every child deserves the finest of trained staff, equipment and facility.

The administrator's concern for the pediatric patient begins at the very entrance to the hospital. The first impact on the child and the child's family should be attractive, warm and friendly. Any waiting area, be it the outpatient clinic, the emergency room, the hospital admitting office, or the visitors' waiting room for inpatient accommodations, should be colorful, comfortable, and should give the patient the impression that the hospital is a friendly place. Colors and furnishings in a pediatric unit should be keyed to the child's viewpoint.

SEE CHILD AS PERSON

It is important for the administrator and all persons dealing with the child to remember that we are not dealing with a small adult but rather with a human being who happens to be young in years but who has definite likes and dislikes, ideas and opinions. The administrator should bear in mind that all children, hospitalized or not, love and need company. If the child has a private room, living-in accommodations should be provided for the mother, who is needed for the child's continuity of security. All other pediatric accommodations should be multi-bed accommodations which appeal to the child's need for the company of other children.

There are administrative problems involved in the placement of patients in pediatric care which stem from the need for grouping by diagnosis, age, and sex. Administrative decisions are sometimes necessary due to expediency rather than for the welfare of the child. Although these decisions may conflict with the child's care, every possible consideration must be given the child.

Proper lighting in pediatric care differs from that in adult care in that the children need plenty of general lighting in the daytime, and nursing procedures require adequate lighting at night in order that a vigilant watch can be kept over the children while sleeping. Night lights installed a few feet from the ceiling rather than a few feet from the floor cast enough general light on the room for the night nursing staff to view the patient. Then, if it is necessary to carry out nursing procedures, there should be an individual switch light over each patient so that others in the room are not disturbed. The problem of watchful vigilance at night will be ideally handled when we have closed circuit televisions in our hospitals operated with black light, so that each child can be viewed from the nursing station via a monitoring system, without turning on lights in the patients' rooms.

The usual patient-nurse call systems found in general hospitals should be provided in the pediatric unit. It is best to use both a light call system and an intercommunication call system in order to care adequately for children of all ages.

The hospital administrator must provide not only the best possible equipment for the medical and nursing staff, but also the best type of furniture and equipment within the patient's room. Proper beds are important. At certain ages children attempt to climb out of bed without realizing the danger of falling. The type of paint used on bed surfaces is also important. Chrome finished beds are ideal because they eliminate the problem of paint and possible poisonous effects on the child. Bedside stands, feeding trays, restraints—all are items which must receive special consideration, not only from the standpoint of physical safety but also for their psychological effect.

DIVERSIONAL ACTIVITIES

Many types of diversional activities are necessary for the hospitalized child. The school program, occupational therapy program, recreational program, group play areas, television, radio, record players, movie projectors

(Continued on next page)

* Mr. Price is administrator, Children's Memorial Hospital, Chicago. This paper was part of a symposium on "The Hospitalized Child," given at the Tri-State Assembly, Chicago, April 30-May 3, 1956. For another paper from this session, see HOSPITAL TOPICS for September, pages 83-84.

and tape recorders, all play a vital role in filling the hours with happy, directed activity. Much can also be provided through a well-organized volunteer program.

The school teaching program in pediatric care is essential, not only because it helps children keep up with their school work, but also because it helps fill the endless hours when medical and nursing procedures are being carried out. The administrator should provide adequate space for teaching, adequate storage for materials and, most important, proper lighting within the inpatient rooms.

Another phase of service for the hospitalized child which concerns the administrator is the religious program. Ideally, each hospital should have a small chapel where patients can be taken for short religious services. A chaplaincy program should be set up within the hospital, keyed to the specific needs of the hospital and the community.

The hospital administrator should view the hospital's visiting hour policy as a service necessary for the well being of the child. There is general acceptance among pediatric hospitals that visiting hours should be very liberal and that the presence of one or both parents is highly desirable. Parents should participate in the care of the child and be able to talk to physicians, nurses, medical social workers and others involved in the patient's care, so that they can properly care for their child when he goes home.

When the hospitalization of the child is on an elective basis and can be planned in advance, there are things that the administrator can do to implement the preparation of the child. One is the use of a story book, setting forth the hospital story in a short and simple manner, perhaps with lined sketches so that the child can use it as a coloring book. This book could be sent to the family and to the offices of the medical staff members. It could also be placed in the hospital admitting and waiting rooms.

ATTITUDE OF PERSONNEL

The administrator must always concern himself with the attitudes and approach of hospital personnel. The very finest of preparation for a hospital stay and the finest of medical and nursing care can be offset by an unkind of unthinking remark made at exactly the wrong time. In the care of hospitalized children we deal with families who are extremely anxious about the welfare of their child and are therefore sensitive to everything that is said and done in the hospital. Correct orientation of all persons in the hospital — personnel, medical staff and volunteers — is therefore extremely important. One basic requirement is for all personnel to make honest and forthright explanations to parents and patients of the procedures to be followed during hospitalization.

SPECIAL DUTIES

There are many special technics in the care of the hospitalized child for which the administrator must provide special facilities. For example, in preparing the child for surgery, many hospitals have special anesthesia rooms with special toys or wall treatments. Equipment and facilities must also be provided for proper isolation technic in order to avoid exposure to contagious diseases.

The hospital administrator is always aware of the fact that a hospital cannot be like a home by its very nature. However, he must provide a "homelike" atmosphere whenever and wherever possible. Mealtime is particularly important. At home this is the time when the family is together and the child is enjoying himself. In the hospital, every effort should be made to make meal hours enjoyable and they should not be interrupted by medical and nursing procedures.

All of this service is costly and provision must be made to cover that cost. The hospital administrator must be vitally interested in prepayment hospitalization plans and in the continued fund raising efforts required to cover the free care aspects which inevitably go with a pediatric unit. It has been said that the appeal of a child and his needs is a natural for fund raising. However, it still takes a lot of hard work and the administrator must take every avenue of approach, not only for special projects and research, but for general operating expenses as well.

IN SMALL COMMUNITIES

What can an administrator do in communities where it is not possible to obtain the services of such people as psychiatrists, psychologists, medical social workers, and others? In such communities, the hospital administrator can see that the service provided is warm and friendly, that the food served is appealing and of excellent quality, that the medical and nursing service is the best obtainable within the community, that proper furnishings and decorations are used within his hospital, and that the community school program is brought to the bedside of the child.

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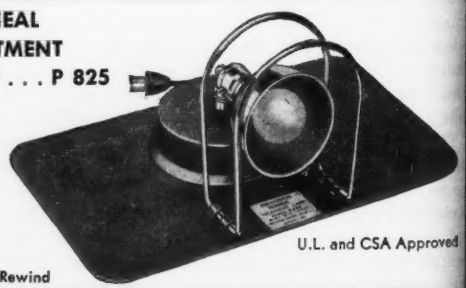

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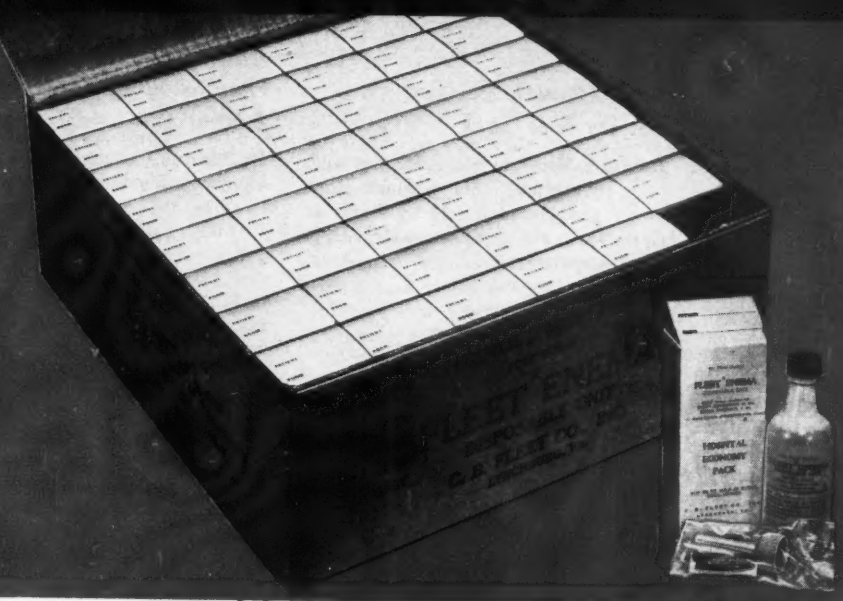

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TRADE TOPICS
(Continued from page 52)

Medical and Surgical Consulting Service Opens

William E. Schulz has opened offices as a marketing consultant to the medical and surgical trade, at 40 Evergreen Drive, North Caldwell, N. J. He has been in the surgical and medical field for the past 20 years.

New Products Division For Davis & Geck

Davis & Geck surgical sutures and other operating room products formerly produced and sold by Davis & Geck, Inc., will now be marketed by surgical products division, American Cyanamid Co. The newly named surgical products division will continue under the direction of Henry Wendt, Jr.

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*without phenol anti-pruritic astringent

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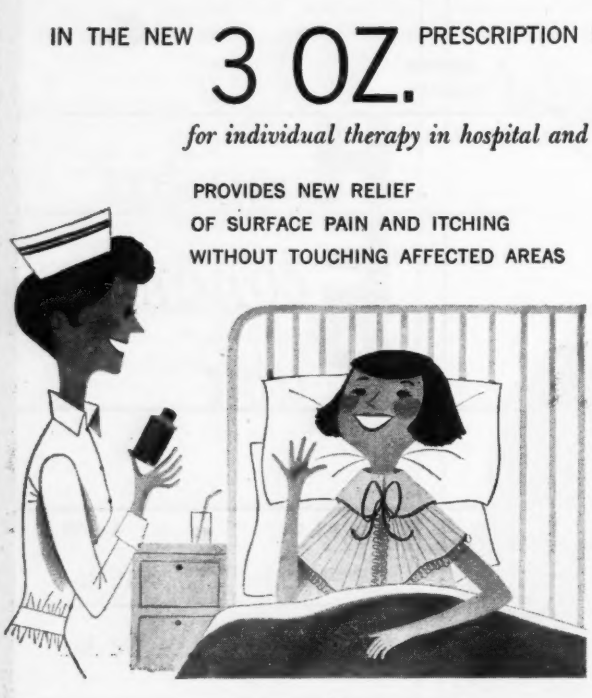

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Pharmaceutical Chemist Added at Cutter

Dr. Marcus G. Van Campen, Jr., well-known authority on pharmaceutical chemistry, has joined Cutter Laboratories, Berkeley, Calif., as vice-president for research.

He was formerly associate director of research, William S. Merrell Co. Dr. Van Campen succeeds Dr. Howard M. Winegarden who retired.

Jack Egan Opens Hospital Consulting Service

Jack Egan recently announced the opening of his own company specializing in hospital equipment and consulting.

The J. J. Egan Co. is located in the Chanin Building, 42nd Street and Lexington Avenue, New York City.

Mr. Egan has been in the hospital field for 25 years in the selling and consulting line. Formerly he was sales manager for S. Blickman, Inc., for nine years.

He has also served as consultant to various government agencies in the United States Public Health Service.

Briefs

Ransom M. Cook has been elected director, Cutter Laboratories, Berkeley, Calif.

* * *

Gudebrod sutures will be distributed in Puerto Rico by James Shine, Sucrs., Inc., Santurce, Puerto Rico, and in Havana, Cuba by Medical Therapy Distributor Corp., S. A.

* * *

Levinthal Electronic Products, Inc., has undertaken construction on the first unit of a new plant in Stanford Industrial Park, Palo Alto, Calif.

The building will be devoted to administrative, engineering, and research activities relating to work in high-power microwave equipment for radar, data transmission, missile guidance, and telemetering.

* * *

George R. Platt — has taken over the duties of advertising manager, Vacuum Can Co., Chicago.

* * *

Anthony J. Zoeller has been appointed administrative vice-president, Champaine Co. He will assume executive directorship of the company.

PERSONALLY SPEAKING

(Continued from page 61)

Spokane, Wash. She was formerly chief, nursing service, VA Hospital, Cheyenne, Wyo.

Mary Cline — is assistant chief, nursing service, VA Hospital, Pittsburgh, Pa.

Catherine Coffey—has been appointed chief, nursing service, VA Hospital, Lincoln, Neb. She was formerly assistant chief, nursing service, VA Hospital, West Side, Chicago.

Jacqueline Davis—is now assistant chief, nursing education, VA Hospital, Boston, Mass. She had held a similar position at Albany, N. Y.

Antonina diBenedetto—has been appointed assistant chief, nursing service, VA Hospital, New Orleans, La., where she was formerly a supervisor.

Alma Erb—has been named assistant chief, nursing service, VA Hospital, Pittsburgh, Pa. She was formerly at Salisbury, N. C.

Irja Feek—is assistant chief, nursing education, VA Hospital, Seattle, Wash., where she was formerly a head nurse.

Mary Finnen—has been appointed assistant chief, nursing education, VA Hospital, Brooklyn, N. Y.

Ruth Fortney—is now chief, nursing service, VA Hospital, Coral Gables, Fla. She was formerly assistant chief, nursing service, Long Beach, Calif.

Mary Gorrow—is now assistant chief, nursing education, VA Hospital, Ft. Harrison, Mont.

Millicent Griffith—has been appointed assistant chief, nursing education, VA Hospital, Lyons, N. J.

Julia Hockstatter—has been named assistant chief, nursing education, VA Hospital, Downey, Ill.

Bernice Jenuskevice—has been assigned as assistant chief, nursing service and education, VA Hospital, White River Junction, Vt.

Barbara Landauer—is chief, nursing service, VA Hospital, Coatesville, Pa. She had held a similar position at Oteen, N. C.

Lenna Larson—has been appointed chief, nursing service, VA Hospital, Walla Walla, Wash. She was formerly assistant chief, nursing service, Brecksville, Ohio.

Joseph Maher—has been assigned to VA Hospital, Perry Point, Md., as assistant chief, nursing service. He was formerly a supervisor, Martinsburg, W. Va.

Ava Maness—is chief, nursing service, VA Hospital, Hot Springs, S. D.

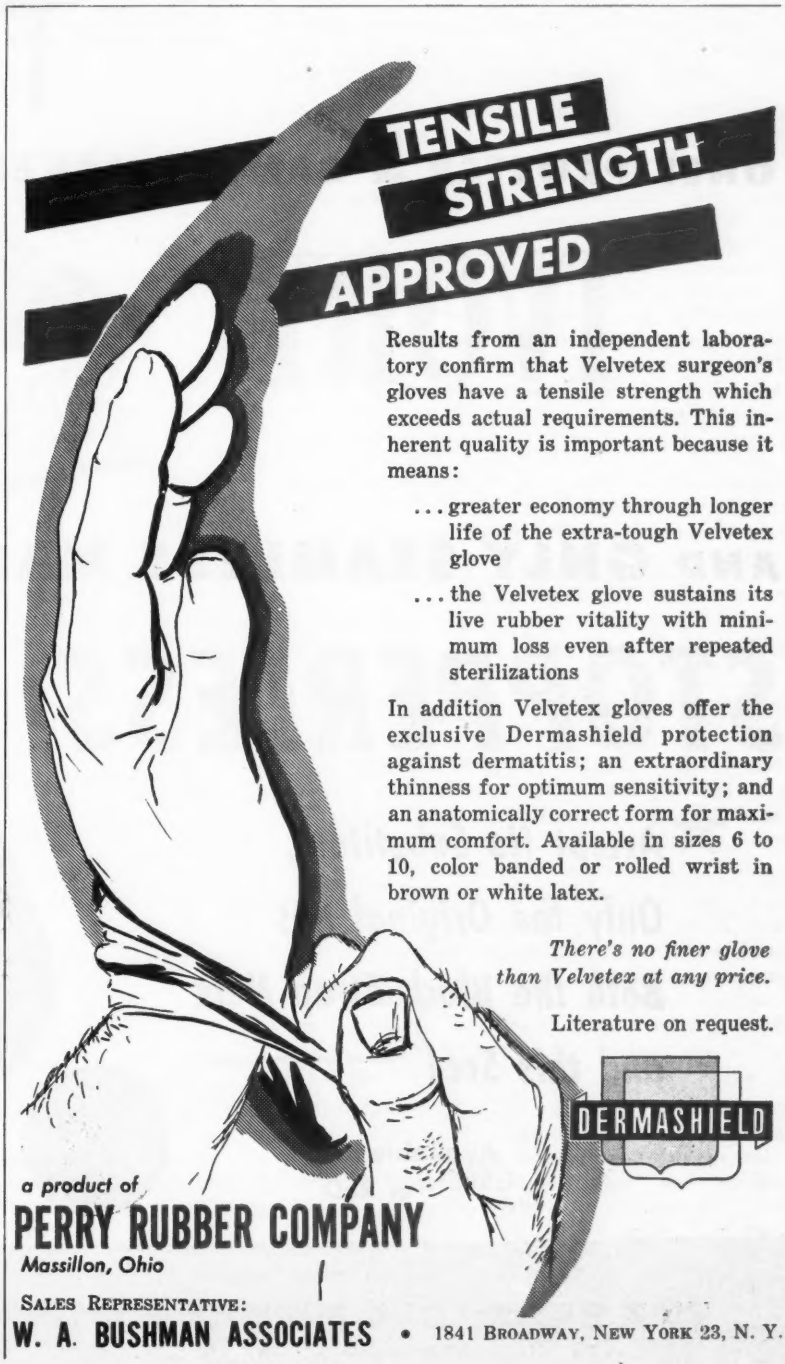
Hazel Mathewson—has been named assistant chief, nursing service, VA Hospital, Walla Walla, Wash.

Ruby Miller—has been appointed assistant chief, nursing education, VA Hospital, Murfreesboro, Tenn.

Frank Morrison—has been assigned to VA Hospital, Salisbury, N. C., as chief, nursing service.

Dorothy Moses—is now assistant chief, nursing service, VA Hospital, Los Angeles.

(Continued on page 132)



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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

• Can State Workmen's Compensation Boards Set Hospital Charges?

I have had many interesting legal inquiries from officials and employees of hospital corporations. From time to time, as outstanding higher court decisions were rendered, I listed important cases in contemplation of writing a general discussion involving these questions for readers of HOSPITAL TOPICS. Knowledge of the cause and outcome of these decisions will help readers conduct their business in a manner designed to avoid future legal controversies. Readers and their lawyers may advantageously cite and use the hereinafter new decisions to win unavoidable law suits. They will do well to clip this article for future reference.

An official of a large hospital corporation wanted to know whether or not the chairman, or other official, of the State's Workmen's Compensation Board may legally make a schedule of charges for private hospitals in workmens' compensation cases. After consistently reading and studying all recent higher court decisions reported in the Advance Sheets in all states of the United States, I was fortunate in locating a new higher court decision which clearly answers this important legal question.

BROOKLYN HOSPITAL BRINGS SUIT

For illustration, in Brooklyn Hospital v. Chairman of the Workmen's Compensation Board, 132 N. E. (2d) 489, the testimony showed facts, as follows: A law of the state of New York authorizes and directs the Chairman of the State Workmen's Compensation Act to establish a schedule "of minimum charges and fees for medical treatment and care" of employees injured within the scope of the State Workmen's Compensation Act. In other words, the fees which the Chairman may fix by schedule are for "such medical treatment and care." Hospitals and hospital services are nowhere mentioned in the law. Nevertheless, the Chairman of the New York State Workmen's Compensation Board fixed a $14.00 per day fee in workmen's compensation cases for bed, board, routine nursing, ordinary dressings and drugs, in hospitals with 50 or more beds; a fee of $11.25 per day was fixed for similar services and accommodations in hospitals with 49 beds or less. The order further directed that: "The total charge for all services rendered in any case shall not exceed the total charge for like services which would be made to a self-paying patient in a noncompensation case at minimum established fees for the particular hospital, in the event the hospital fees in such noncompensation cases are lower than the fees provided by this schedule." It was agreed that the effect of this order is to fix a $14.00 daily fee per bed in a semi-private room in a non-public hospital ($11.25 per day in smaller hospitals) with the proviso that the per diem charge per bed for any workmen's compensation case in any private hospital shall not be higher than the hospital's regularly established minimum fees for such accommodations when furnished to a self-paying patient.

The Brooklyn Hospital and the Hospital Association filed suit and asked the court to prevent enforcement of this order.

Fundamentally, the complaint against this mandate or schedule was that it compels the hospitals to furnish hospital accommodations in workmen's compensation cases at prices no higher than those that the hospitals themselves have established for self-paying patients. This means that insurance companies and self-insured employers in workmen's compensation cases not only get the benefit of minimum fees, which have been fixed below cost for needy people, but the order means also that the deficit resulting from charitable practices must be made up by donations to the hospitals, all to the benefit of the insurers and self-insured employers. Also, the legal counsel for the Brooklyn Hospital and the Hospital Association argued that the schedule of rates established by the Chairman is invalid and void because there is no state law authority whatever for the fixation by the Chairman of any fees for hospital services.

COURT CONCLUSION

It is interesting to observe that the lower court held that, the schedule of fees fixed by the Chairman was valid and impliedly authorized by the above mentioned New York State law. However, the higher court reversed the lower court's decision and held that the Chairman's schedule of hospital rates was invalid and unenforceable. This higher court said:

"All of this on its face means to us that the schedule-fixing power was intended to apply to the fees of physicians only. When it came to authorizing a schedule of fees, the word 'hospital' was omitted while the word 'medical' was left in and there were references to the president of the State Medical Society and to 'physicians.' When the Legislature intended to cover hospital matters as well as medical matters, it used both the words 'medical' and 'hospital.' "

Therefore, it is quite apparent that officials of the State's Workmen's Compensation Board cannot lawfully adopt and enforce a schedule of hospital rates when the state law merely gives such officials authority to establish rates and charges for "medical" treatment and care" of employees within the scope of the State Workmen's Compensation Act. In other words, officials of the Workmen's Compensation Board cannot establish a valid rate for hospital charges, unless the state law specifically authorizes such officials to establish minimum hospital fees and rates.

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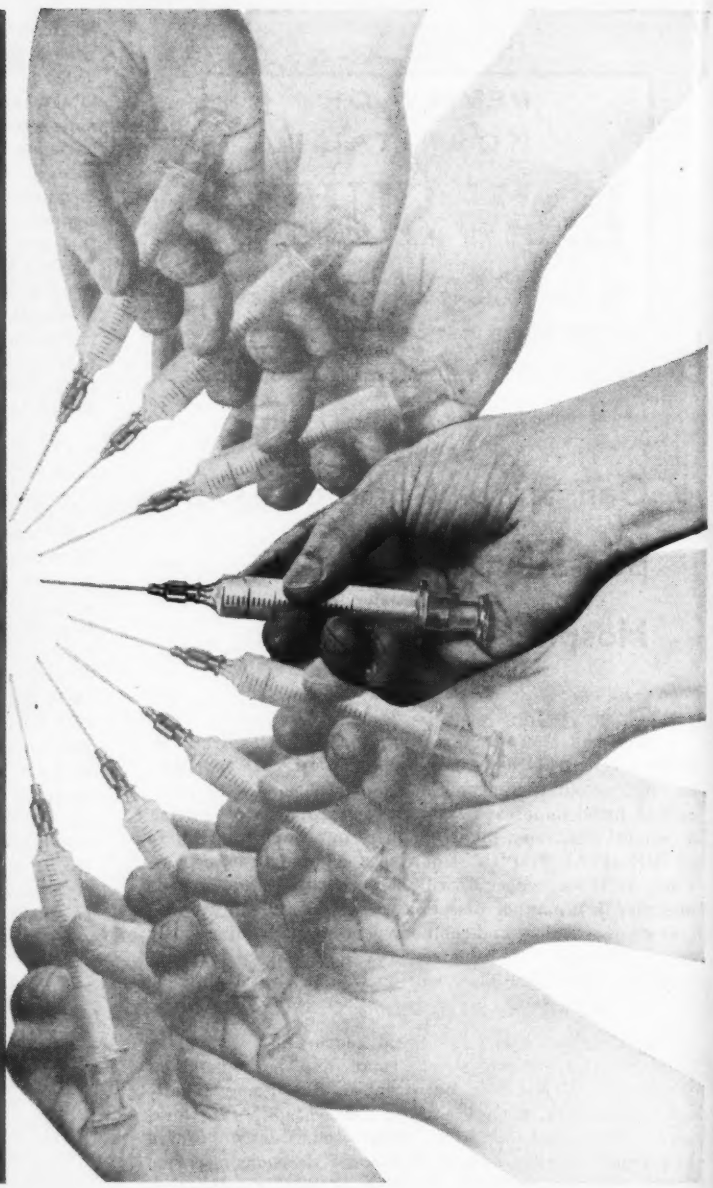

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Multiple-dose Vials, **10 ml., each ml. containing 25 mg. Pyribenzamine hydrochloride; cartons of 1, 6 and 50.**
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World Leaders in Blood Research, Allied Fields, Meet in Boston

• *Renowned scientists from many countries presented papers and viewed technical and scientific exhibits at the sixth bi-annual congress of the International Society of Hematology, August 26-September 1. On September 3, 4, and 5, the society held a joint meeting with the International Society of Blood Transfusion and the American Association of Blood Banks.*

Abstracts of some of the papers presented follow.

A-Bomb Victims Require Blood, Good Surgical Care

Communities Must Depend On Local Banks for Blood

Blood transfusion is not a specific form of therapy for atomic attack. Transfusion alone will be useless in increasing survival. It will be valuable when used with high-order surgical care. The problem of treating mass casualties is not one of blood or banks, but rather one of providing able surgical care with limited facilities.

It is estimated that with the present blood bank set-ups in the country, 150,000 units of blood could be collected in a day. In wartime, medical supplies have low transportation priority, and most of the blood used in any community will have to be collected locally.

The demand for blood to meet immediate requirements will be almost nil. If 100,000 units were available immediately, they could not be used, because the many casualties could not be sorted and treated in time. Use will be excessive, but the need will be modified by circumstances. Many casualties will appear in an instant. Optimum situations for blood transfusion will not be available in that it will be impossible to sort the poor risk casualties.

In the Korean War, blood was available in unstinted quantities in almost all stations. Whole blood was used in preference to all other agents, such as plasma, etc. Eighty percent of the wounded received no transfusions; the 20 percent transfused were the most severely wounded. Since the use-factor of blood in World War II was zero, it can be assumed that some of the Korean casualties would have recovered without transfusion.—**William H. Crosby, Jr., M.D., Chief, Department of Hematology, Walter Reed Army Institute of Research, Washington, D.C.**

Thymol Turbidity Tests Detect Viral Hepatitis Carriers

Study of Donor Group Proves Significant

A substantial number of blood carriers of viral hepatitis could be detected by a group of hepatic function tests and by thymol turbidity studies alone, but complicated hepatic function tests are impractical for most blood banks.

Carriers of viral hepatitis can be positively identified only by inoculation of their blood into human volunteers. Investigation of all blood donors is impractical, but we studied

(Continued on page 95)

Right: William Dameshek, (r.), Boston, Mass., past president, International Society of Hematology, greets the society's new president, Giovanni di Guglielmo, M.D., Rome, Italy.

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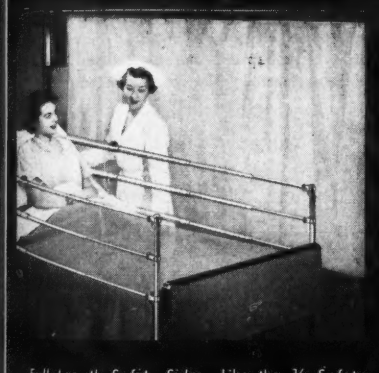

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Above: Association officers at the meeting pictured here are (l. to r.): James J. Griffitts, M.D., Miami, Fla., president, American Association of Blood Banks; I. S. Ravdin, M.D., president, International Society of Blood Transfusion, and Louis K. Diamond, M.D., Boston, Mass., vice-president of the society.

Left: Dr. Griffitts presents the gavel to E. E. Muirhead, M.D., president-elect, American Association of Blood Banks.

Below: Henry Turkel, M.D., consultant, educational training division, Surgeon General's Office, United States Army, demonstrates the technic of infusion via the bone marrow to Miss Janet Haas, medical technologist, Buffalo (N.Y.) General Hospital and J. T. Williams, M.D., Lincoln, Nebr. Severely burned patients or those in severe shock, with veins inaccessible or collapsed, can be infused with fluids or blood through the bone marrow using a special trephine type needle.

(Continued from page 91)

a group of donors whose blood resulted in viral hepatitis in the recipients of the single transfusion.

The results of hepatic tests on these donors at first examination showed two-thirds to be in the positive range. Even considering the possibility of the recipients having acquired the disease from other sources, the coincidence was ruled out to satisfaction.

A thymol turbidity test supplemented by thymol flocculation is easy to do and is economical. Even considering that some carriers do not have abnormal thymol turbidity, it is believed that the number of carriers thus detected would be significant. Thymol turbidity tests are not necessarily specific for liver disease and viral hepatitis, but people with abnormal thymol measurements cannot be considered healthy donors, even if they voice no complaints of poor health.

When compared to the total donor population, the number of proved and suspected carriers with abnormal tests would be significant. Data collected to date is not sufficient for indicating proportions of carriers with abnormal hepatic function tests in contrast to carriers with normal tests.

—Robert F. Norris, M.D., Professor of Clinical Pathology and Director, William Pepper Laboratory of Clinical Medicine, University of Pennsylvania, Philadelphia.

Discuss Possibility of Citric Acid Intoxication

One Symptom is Persistent Hypotension Under Anesthesia

Citric acid intoxication, while rare, is nevertheless a possibility in patients who receive many transfusions rapidly or who have a disturbance in ability to eliminate citric acid. Whenever hypotension persists in the anesthetized patient who is apparently receiving adequate blood replacement, citric acid intoxication should be suspected. If it is the responsible factor, a prompt, brief rise in blood pressure should result after intravenous injection of 0.5 gm. calcium chloride (187 mgm. Ca.).

There is no dependable basis for predicting how high a level of citrate exists in the body during transfusion. Since calcium leaves the blood stream rapidly, a continuous infusion is necessary to maintain a reasonably high elevation in serum calcium. A one percent solution of calcium chloride (1 gm./150 lb. of body weight) given in 10-15 minutes as a priming dose and followed by 1 gm./hr is usually effective.

When blood is infused at a rate greater than 500 cc./15 minutes, citrate is not diluted and remains in the vascular compartment. Under these circumstances, it is suggested that 0.75 gm. calcium chloride be given slowly in a separate vein for each 500 cc. of blood infused.

If massive transfusions are anticipated, the use of citrated blood should be avoided. Blood collected over an ion-exchange column is free of calcium, and although massive infusion of blood collected in this manner may result in a fall in serum-ionized calcium, the treatment is simple and accurate.

Infusion of red cells resuspended in saline also eliminates most citrate. A small amount, however, always remains and, in addition, calcium must be added to the saline, or the preparation is calcium-free. The suspension also lacks plasma proteins and many

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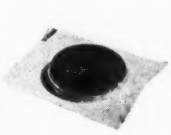

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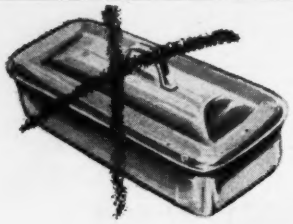
hemostatic substances.

Blood collected in Versene (ethylene diamine tetra-acetic acid) is dangerous for routine use, because although it prevents coagulation of blood, there is no reason to suppose that the body can tolerate or dispose of large excesses of Versene any better than it can citrate. Whereas the body can metabolize large amounts of citric acid as well as excrete it by the kidney, Versene is apparently only disposed of by the kidney.

There is little experience with heparinized blood, but it is doubtful that the body could accommodate the substance or that coagulating difficulties could be controlled with protamine. Citric acid or other chelating agents should be avoided altogether when extremely rapid transfusion of blood is anticipated, during hypothermia, or in patients with severe liver disease.—**John Bunker, M.D., Assistant Clinical Professor of Anesthesia, Harvard Medical School, and Associate Anesthetist, Massachusetts General Hospital, Boston.**



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2. Components must be combined aseptically.
3. The finished product must meet U.S.P. sterility tests[2].
4. Each petrolatum gauze unit must be packaged individually to maintain sterility.

(1) U.S.P. XV, pp 304-305. (2) U.S.P. XV, pp 841-846.

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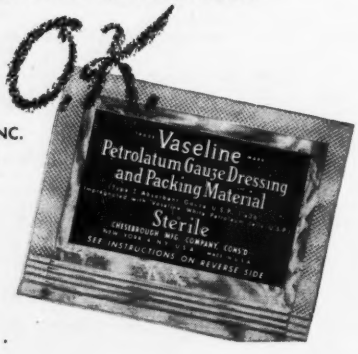

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Fail to Find Reason For Oozing During Surgery

No Apparent Connection Between Oozing, Transfusions

Oozing from small blood vessels is a problem in the operative field, in obstetrics and following multiple transfusions. In extensive studies, no single factor could be demonstrated as the cause of oozing during surgery.

In 78 patients operated on extensively for malignant neoplasms, 16 oozed. None of the oozing was prolonged or intractable, and in most cases it involved a major blood vessel and was not generalized.

No clear-cut relationship was demonstrated between the patients who oozed and the number of transfusions received. In patients receiving less than four units of blood, the platelet count change was minor; five to eight units resulted in a drop in platelet count of from three to 68 percent, and patients receiving over eight units showed a drop of from 44 to 83 percent. In all the platelet count was over 100,000. Thrombocytopenia is apparently not an important factor in abnormal surgical bleeding. —**Marjorie B. Zucker, Ph.D., M. Siegel, Ph.D., E. E. Cliffton, M.D., J. Weldon Bellville, M.D. and W. S. Howland, M.D., Sloan-Kettering Institute for Cancer Research, New York City.**

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The work is divided into four functions: (1) Blood deplacement from voluntary donors; (2) administration of blood and fluids; (3) care of equipment and (4) teaching.

The department is covered by the regular staff from 8 a.m. to 4 p.m. The intern staff takes over thereafter. In 1955, 1700 units of blood were received, 1200 of which were collected at the hospital. Eighty-five percent of the total was collected by the IV nurses.

Blood is taken from the blood bank only by a physician or a member of

(Continued on page 115)

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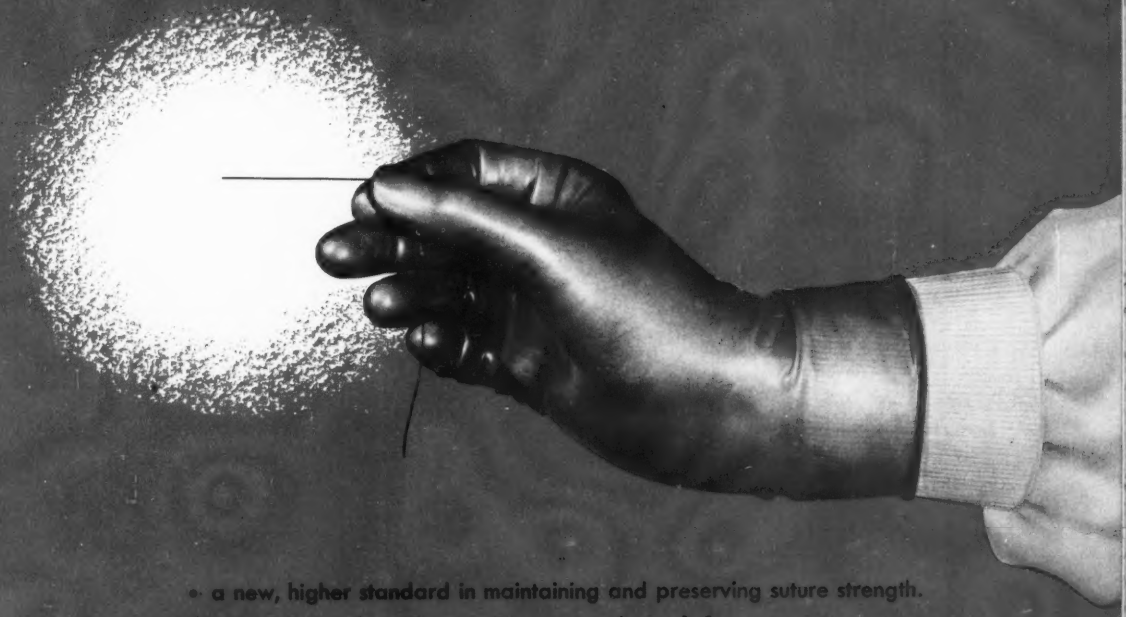

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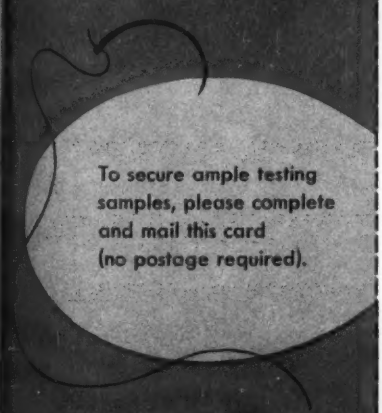

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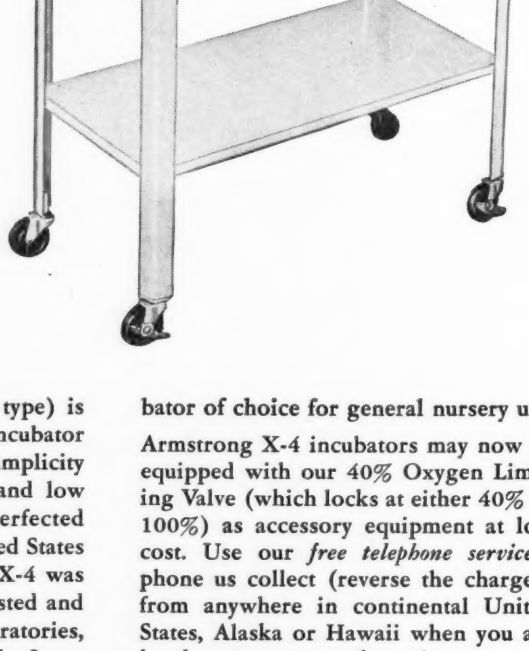

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OB DEPARTMENT

Emotional Problems of Mothers and Newborns

By Robert L. Stubblefield, M.D.

• Psychiatry has focused much of its attention in recent years on the psychological features of pregnancy and motherhood. The evaluation of the normal personality state of the woman during pregnancy is complicated, but we are gradually discovering more facts about the psychological meanings of pregnancy, the symbolic features of the condition, and the complex shifts in the psychological defense system that occur in the mother shortly after delivery.

The complexities of the problems in the evaluation of the emotional state of the pregnant and postpartum woman seem relatively simple, however, when compared with the problem of the evaluation of the emotional problems of newborns. The traditional methods of psychological evaluation used by psychiatrists, and largely developed from psychoanalysis and child psychiatry, consist of study of various verbal communications from patients, including descriptions of fragments of behavior, feelings, dreams, fantasies, and play activity of various kinds.

Naturally, these methods are of no value in the evaluation of the psychological state of the newborn infant, so that we must rely on direct observations of infants' motor behavior and then speculate with wide latitude about the infants' perception of the world.

Fortunately, we are able to bring a rational, scientific framework into our observations. For example, when one thinks of a powerful emotion, such as depression or laughter, one must think also of the accompanying physiological features, such as crying, forced chest movements, etc., since these physiological components cannot be separated from the emotion itself.

With this in mind, we can observe the infant systematically, pay particular attention to various physiological manifestations, and make reasonably accurate inferences about the infant's emotional state. It is my intention to focus on some observable features of behavior of both mothers and newborn infants and to discuss them in relationship to certain current psychiatric theoretical ideas.

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Man is a biological creature, with definite biological needs; he is born anxious, helpless, dependent, and he moves gradually toward independence and maturity over a period of many years; he is constantly subjected to various environmental stresses and may react to them by retreating to a safer, more infantile, and more protected position.

As Freud describes the process, the infant is instinctual, operates on the pleasure principle (I want what I want when I want it), and gradually substitutes to a greater or lesser extent the reality principle by identification with mother and other love objects in life. Thus any theory or partial theory of human behavior must take into account such observable facts as infantile helplessness, narcissism, aggression, regression, and the remarkable ability of the mind to perceive and retain many stimuli and to form adaptive responses from a very early age.

When we consider the emotional problems of mothers, we must take into account all of those factors which influenced her behavior prior to the conception of the child. Among these factors are genetic structure, early life experiences, type of identification pattern established with parent of same sex, significant emotional traumatic events, relative level of maturation and resolution of dependency ties to parents or parent figures. For example:

1. **Genetic factors.** A woman may be conscious of some genetic factor in her family (such as epilepsy, mental retardation, etc.) which may heighten her level of anxiety to pathological proportions during her pregnancy. Or she may be genetically active and aggressive and find it difficult to tolerate the restrictions imposed by her pregnancy.

2. **Early life experience.** A woman may have suffered the type of emotional deprivation described by Spitz, Bowlby, Skeels, and others, and may project her own wish to be mothered to the unborn child, with resulting excessive preoccupation with her own health during pregnancy, and usually followed by a "smothering" type of overprotective love of the child.

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3. **Type of identification with parent of same sex.** Ordinarily this identification occurs in the age range of 3 to 6, with some reinforcement in adolescence. When the girl has identified with a nonfeminine mother who constantly belittles herself or when the girl has been treated as a boy in subtle unconscious or more overt ways by the parents, one can with reasonable accuracy predict much difficulty in accepting the maternal role.

4. **Significant emotional traumatic events.** Largely these events focus on separation, the major problem which the infant and child must master. The loss of mother, temporarily by illness, etc. or permanently by death or divorce, will inevitably produce regression, and create ambivalence about the process of being a mother. It is likely that residuals of these conflicts will emerge during the stress of pregnancy.

5. **Relative level of maturity.** A persistent and excessive attachment to one or both parents, whether due to excessive protection by parents, to a maldevelopment or personality structure, or to other factors, will produce problems in the pregnant woman. One might look at this from a quantitative energy point of view — the greater the amount of energy invested in defending against the old anxieties and hostilities of infancy and childhood, the lesser amount of energy available to the personality to cope with the various problems possibly inherent in every pregnancy.

There is another set of factors which play a significant role in the behavior of the woman during her pregnancy and immediately after it. Pregnancy itself is connected with specific fantasies and meanings to the individual patient; these always have strong connections with the patient's early childhood experiences.

Therese Benedek, in an article entitled "The Psychosomatic Implications of the Primary Unit - The Mother-Child Relationships," *(American Journal of Orthopsychiatry,* October, 1949) presents much of this material in a very challenging way. She points out that the mother develops a symbiotic interaction with the child, appears "regressed" and more infantile, but actually develops a sense of well-being and narcissism and matures as she enjoys her significant role in her pregnancy. In addition, her receptive tendencies are greatly increased — she "eats for two," for example.

To quote Dr. Benedek, "The pregnant woman thrives on sympathy and solicitude of her environment. If, however, her passive receptive needs are unfilled, if her husband or her family are not adequately attentive, the sense of frustration may set in action a regressive process which may increase her receptive needs to an exaggerated degree. The resulting anger may destroy the primary narcissistic state of pregnancy, and thus it may interfere with the development of motherliness."

The nature and content of the fantasies about pregnancy will vary a great deal in individual mothers, depending on their life experiences. When viewed in relationship to current observations and theoretical ideas, one may assume that the content of such fantasies in an individual patient will reflect specific partially solved conflicts out of the past.

Thus, one patient, who had a strong masculine component in her personality, insisted that her child would be a boy, made all of her plans on this basis, and suffered a definite depression when her wishes were frustrated by the birth of a girl. I felt reasonably certain that she would have dominated the life of a son, and would have vicariously acted out her early infantile fantasies about being a boy through him and his behavior.

At a different and earlier psychological level, another patient saw pregnancy as a grand opportunity for complete infantile gratification, precipitated a crisis in her marriage by the extent of her oral demanding behavior.

When the mother delivers her baby, a new phase of psychological adjustment appears. The close symbiotic relationship with the child is interrupted. The child seems a stranger, seems to function without her, and yet has need for her love. The mother, too, has strong needs to love and nourish the child, and she may react to this feeling of loss with depression, the so-called emotional lag, with rejection of the child, completely or partially, with neurotic overcompensation and indulgence, or with a healthy affectual relationship with the child on mutually satisfactory terms. The husband's ability to gratify the wife's dependent oral needs at this point is crucial, as Dr. Benedek points out.

All of these things should have therapeutic implications for us in the field of medicine. For example, we should be interested in a thorough assessment of personality strengths and weaknesses early in pregnancy, with particular focus on evidence of existing marital conflicts. We should be concerned about adequate, continuous prenatal health care, about such matters as possible rooming-in arrangements, flexible visiting periods in the immediate postpartum period, and a large number of factors.

Now I want to focus attention on the child — the healthy, full-term newborn infant. The healthy infant has a number of physiological needs, nutrition, and so on, and he already has some definite psychological needs, as we view him. One can sum them up by relating them to Cannon's concepts of homeostasis: The newborn wants to reestablish the symbiotic relationship that existed prior to delivery, according to some current psychiatric perceptions of the situation.

Through the history of man, one can see many different approaches to this problem, with tremendous variations in practices from one culture to another, even today. These customs have been described in recent years by a number of anthropologists and social scientists, most notably Margaret Mead, Ruth Benedict, and Gaza Roheim. For example, in some countries, particularly in eastern Europe, swaddling is used extensively. Probably no country in the world tries so vigorously to separate mother from child as we do in America in this period, which is not something to point to with pride, in my opinion.

Initially, the infant's pattern is one of crying - gratification - sleep, and the cycle is repeated. For purposes of our discussion, this is perceived by the infant as within

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himself, not with a perception of a self and a non-self. As an analogy, later a child plays peek-a-boo, shuts his eyes, and assumes that you cannot see him. Thus the mother-child unit may be conceived of as a single reflex arc, and the child gradually gains security by consistent gratification by the mother.

We can ask ourselves how the breakdown in this cycle occurs, which in turn leads to the development of an angry, frustrated, crying infant. The answers to these questions seem to be in these general areas, as I view them:

1. **Hospital routines.** These must be designed to deal with a number of factors that make it difficult to meet the specific needs of an individual child. Sybil Escalona's fascinating work on the remarkable differences in small infants, the paper by Ann Stewart and others at the University of Washington on infant-mother relationships, and the Yale University films of mothers nursing very young infants, along with many other reports in the literature, should easily convince us of the tremendous variation in the physiological and psychological needs of newborn infants, and cause us to review and revise our hospital routines regularly with the needs of infants in mind.

2. **Factors in the mother.** As all successful politicians discover and usually exploit, we as individuals are in favor of motherhood, and some of us find it difficult to accept theories that imply that mothers do not love their children 100 percent of the time. Nevertheless, maternal hostility does exist, and it may emerge directly by overt rejection, more subtly by such behavior as refusal to breast-feed the child, or in even more disguised types of behavior that stem from attempts to repress it — such as depression, acute psychotic withdrawal, or somatic conditions of various kinds.

In addition, it is usually possible to note the accompanying reaction in the child. For example, a 10-day-old child of an unmarried mother was admitted for vomiting, promptly improved with the traditional "tender loving care" given by the nursing service, and promptly renewed the behavior when placed with the mother. The child's vomiting stopped when the mother was able to state to the social worker that she did not want to keep the baby.

Finally, one should examine a mother-child relationship within a scientific framework, and with every effort to be aware of and in control of one's own needs and feelings. Perhaps an example may clarify my point. A mother of a premature infant with partial blindness casually said that she would pick the baby up "not today, but maybe tomorrow." Naturally, this triggered off some rather strong resentment in the medical and nursing staff on the ward. This was an attack by the mother directed at them, in a way, since she seemed indifferent to their efforts to preserve her child. Granted that this is an extreme type of case and an extreme type of response in a mother, I merely want to call your attention to the extremely high probability of intense ambivalence by the mother toward that infant.

In summary, I am suggesting that maximal awareness of those factors which operate in normal and abnormal personality structures, maximal awareness of the psychological processes in the woman during and immediately following pregnancy, and proper attention to staff-patient relationships should lead to increasing understanding of the emotional problems of mothers and newborns. With better understanding, nurses and physicians should be able to modify and improve their therapeutic technics with this group of patients.

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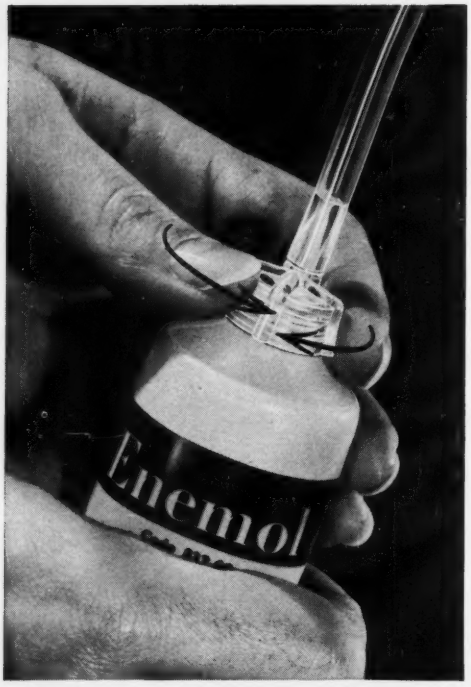

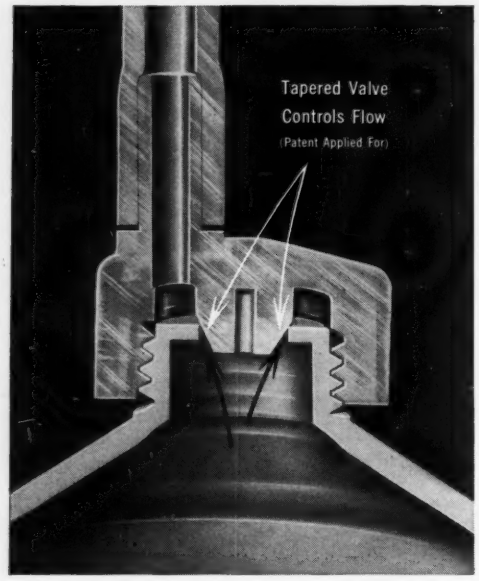

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1. Kehlmann, W. H., Time Study On New Enema Technic, Modern Hospital, May 1955.

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Pittsburgh O. R. Nurses Hold Annual Banquet

• Operating room nurses from the Pittsburgh A.O.R.N. chapter held their annual banquet recently. Attendance this year was higher than at any previous banquet. Part of the group is pictured above.

Officers are: Miss Hartle, chairman, Homestead hospital; Mrs. Lindner, vice-chairman, VA Hospital; Mrs. Grienezion, secretary, Children's Hospital; Miss Rambo, treasurer, Suburban General hospital.

Board members are: Miss Ivory, VA Hospital; Miss Marberger, Allegheny General hospital; and Miss Jimm, Butler County Memorial hospital.

Planning and Managing the Recovery Room

By Eugene D. Rosenfeld, M.D.*

There's a good deal of a difference between the approach to planning a recovery setup in an existing hospital and that to planning one for a new hospital. I've had both experiences.

In the first situation, it is possible to analyze experiences and statistics in the light of the existing program and in the light of hopes and aims. In the second situation, one must guess or project future activities much along the line of what other hospitals of similar capacity have experienced. I think that one encounters a great many more problems in designing a new unit without the background of previous experience.

Where you have an existing hospital, planning a recovery room, it seems to me, should be a joint operation involving the administrator, the architect, and the surgical staff—not the chief of surgery alone. I think one of the biggest mistakes we make in planning is to assume that the chief of a particular department is the only one who has the answers. The entire surgical service, including all the specialties in the hospital, should be consulted—and some of the assistants and adjuncts will have better ideas than the chief.

The final decision, however, on any planning project still must remain with the planning authority, which means the administrator, the consultant, and the architect.

I think that the planning team should include the O. R. supervisor and her staff. I do not believe the O. R. supervisor or O. R. nurses should be in charge of the recovery unit. But certainly the surgical supervisor is a key person in the planning operation, and so are the nurses who are going to staff the unit—at least the head nurse should be in on the planning operation.

The central supply supervisor should be consulted, because most, if not all the production of trays, packs, instruments, etc., should take place in the central supply, *not* in the recovery unit. Recovery unit nurses should be free to take care of the patient.

By all means, the anesthesiologist and his group are vitally important in the planning.

One must start, it seems to me, with a breakdown of previous experience. How many operating rooms are in action, and how many are you going to put in action? What type of cases are you doing, and what type of cases are you going to be doing? Are a good portion of your surgical procedures to be majors, or minors? If majors, what kind of majors? How long is your postoperative follow-up and recovery period apt to be in the average case?

Look at the surgical ward. Find out how much time is spent by special duty nurses in taking care of postoperative patients when no postoperative unit exists.

Find out the attitude of the surgeons and the anesthesiologists on what constitutes good postoperative care.

DO NOT go by a rule of thumb. Many articles tell just how many postoperative beds you should have. Probably the best planning booklet on the postoperative recovery room is the one the U. S. Public Health Service issued in 1952. It says that a hospital of 100 beds with two major operating rooms should have three recovery beds. The formula is: a bed for each operating room plus one. In a 200-bed hospital, the formula becomes a bed for each operating room plus two; in a 300-bed hospital, a bed for each operating room plus three.

I don't believe these figures are as valuable today as they were when they were first recorded—for this reason: In our own experience, we planned eight beds for four major operating rooms and three minor operating rooms—but for seven operating rooms, eight beds have proven inadequate. We'd like to have 10. The formula would be revised to provide two beds for each operating room plus two.

PLAN FOR MAXIMUM USAGE

I do not think any formula can be used. One must plan for the maximum usage, the maximum need, the maximum demand—not for an optimum or a minimum or an average. Take into consideration that there will be times when some postoperative patients will spend longer hours, and larger numbers will spend longer hours in the recovery room than on the average. It's the facilities needed on that day that one must plan for to do a competent job with the recovery room.

A recovery room placed at a distance from the operating suite may cause tragedy. In my estimation, a recovery room is part and parcel of the operating suite. It should be as closely integrated physically as possible. In the Long Island Jewish it is part of the same facility. You enter the operating pavilion through a corridor, and the recovery room is off the same corridor. The patient can be taken off the operating table onto the recovery bed, and the bed rolled right into the recovery room.

The distance and the time factor are cut to a minimum, and I think that this of course accounts in part for the excellent clinical results we've had with the recovery room.

In planning for an existing institution, take all these things into consideration and you may find, as Montefiore (New York City) did, for example, that most of its surgery was major surgery, and difficult surgery. Many patients had such major procedures as hemipelvectomies and operations of that type. In that kind of hospital, I think you ought to consider the recovery room as a postoperative group nursing unit, not simply as a recovery room. You need both. You must be prepared to care for the postoperative patient who is having a very stormy course, and take care of him in lieu of special-duty nursing. That's the dual philosophy I think you must bring to postoperative recovery units.

In our experience, the average patient with a minor procedure and a short anesthesia is in the unit for a half hour to an hour, until he has recovered from anesthesia, his vital signs are stabilized, and he is ready

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to go up to his room.

But the average major surgical patient is in for three to four hours before he is considered ready to go to his room. Not too infrequently we have patients who stay overnight in the recovery room, and we have had patients who have stayed many days. In fact, one of our first major problems at the hospital was a craniotomy on a very young girl who had a spontaneous unexplained cerebral hemorrhage. She was in the recovery room, I believe, about 18 days.

Patients who stay in the recovery room beyond the half-hour or hour period are usually those who have undergone cardiac surgery, central nervous system surgery, chest surgery, and occasionally complicated abdominal surgery, although most of these patients do very well today.

I think this dual use of the recovery unit pays great dividends, particularly when special-duty nurses are so difficult to come by, and when the average special-duty nurse is not well trained for the care of the truly difficult postoperative patient. Getting specially trained nursing personnel who understand the requirements of a postoperative patient is a very vital part of staffing a postoperative group nursing unit. I think one should start months in advance of the actual opening to plan and train the personnel—not just plan the physical facilities.

Planning a recovery unit for a new hospital requires that you anticipate certain requirements. Will the average hospital's experience be yours, or for special reasons because of special programs, will you take on special problems and must you plan, in addition, more space for more activity?

One question that will come up in your planning is whether the recovery room should stay open 24 hours a day, seven days a week.

If you conceive of its function as we do, as a combination recovery and postoperative or group-nursing unit, it *must* stay open 24 hours a day. The postoperative nursing personnel must be available for emergencies that take place after the routine operating schedule of the day, for the patients who stay overnight, and for the patients who occasionally stay a number of days.

STAFF FOR EIGHT-BED UNIT

For our eight-bed unit we have a staff that consists of a head nurse, two staff R.N.'s, and one aide, for the 8-4 shift. We have one R.N. who is on from 12:30 to 9 p.m.; one who comes on at 4 p.m. and stays on until 12 midnight, and one who comes on at 12 midnight and stays till 8 a.m. So, in all, we have six R.N.'s plus an aide. In addition, we've been fortunate in having a volunteer who is an R.N., who loves the recovery room work and is there four full days a week.

It takes that large a staff for an eight-bed-unit, 24 hours each day. There will be times when there'll be no patients in the recovery room. I think that in staffing the room, it should be made plain that when such a situation exists, the nursing administration and the administration of the hospital will feel free to transfer the recovery room personnel temporarily to other units in the hospital, with the full understanding that they'll return immediately to the recovery room as soon as a patient is there.

I think to try to do it the other way around—to transfer personnel from other units in the hospital to the recovery room — is bad planning, bad personnel administration, and can only result in heartaches.

Even with the kind of management I'm suggesting, you'll find nurses assigned to the recovery room who resist and resent being transferred even temporarily to other units in the hospital.

RECOVERY ROOM LAYOUT

If you look at recovery room layouts in various hospitals, you'll notice that when they were built in existing hospitals, they took the form of the available space. When they are built in newly available space, preferences for layout seem to vary considerably. In my estimation the best form is a sort of horseshoe, with the nurses stationed in the open end of the horseshoe so that they have direct visibility and the least distance to travel to patients' beds.

Recovery units should be open areas. In the Montefiore unit, there was visibility from the nurse's station of all of the beds, but through glass-partitioned cubicles. Montefiore still continues to use this unit, but as a group-nursing unit. Five more beds have been added in an open unit for the immediate postoperative recovery room functions for those who stay for an hour or two.

Our unit is entirely open, divided only by curtaining. We are often asked, "Is this possible? Can you mix the sexes? Can you mix the ages? Can you mix different types of patients in a postoperative recovery room?"

You can, and you do. Most of the patients are not too concerned about who their roommates may be at that particular time. By the time they might get too concerned, they're ready to be transferred back to their own room.

The open unit gives much better control of the patients than you would have with partitioning made entirely of glass.

Most of the units have solved the early problems — one of which was how to place beds in a recovery unit. We traditionally place beds with the head against a wall. Then we have difficulty because we can't move back behind the bed unless we move it out. Placing beds against a wall also requires that the oxygen and suction equipment, which should be piped in, be placed at a height above five feet so that the back of the bed will not knock it off the wall. Reaching up that high to handle gauges, and so on, is difficult. The gauge ought to be down at a level of about 3'6" or 4', which is the normal height at which most of us can easily work. If you place your outlets at this proper height, the back end of the bed may knock the equipment off the wall or damage it.

We have placed a stainless steel bedside table, containing much of the immediate equipment needed in the care of the patient, between the head of the bed and the wall. That table is about 30" high. The piped suction and oxygen equipment is just above that height and immediately handy.

We have also used specially designed beds — similar to the old "I" beds, which had the same height at the tail end and head end. If you use a standard bed that has a high head end, turn it around — make the head end the tail and the tail end the head — and put the patient's head at the tail end. I think you'll find it'll work much better.

To plan for this use of bed and bedside table, you must leave about 10 feet from the wall for the bed, and about four feet of aisle space beyond that. I think planning this way pays great dividends.

ROUTINES FOLLOWED

Routines should be planned as far in advance as possible. It's routine in our recovery room for vital signs — blood pressure, pulse, and respiration — to be checked every half hour unless otherwise indicated by

(Continued on next page)

the surgeon or the anesthesiologist. At the same time, if any of the following are in use, they are also checked each half hour: levine tube, dressings, drains, intravenous tubing, needles, whether for transfusion or infusion, and oxygen equipment. Tidal drainage or any other kind of drainage also must be checked at that time.

The patient's charts should not be placed in a chart rack or on a table, but should be hung at the base of each bed. In addition, a visual chart with large markings ought to be at the base of the bed, perhaps on a board, on which the nurse marks the vital signs. I think this is important, because then the nurse, the anesthesiologist, the surgeon, or the resident can tell at a glance what the course of that patient has been. I think it should be unnecessary to have to go to a chart that's in a rack or on a table. You're not worried here about patients or visitors getting to your charts.

SUPERVISION OF UNIT

Who supervises the recovery room? It should not be the O.R. supervisor. She has all she can do to run a good operating room. She should be in close contact with the head nurse in the recovery unit; they should be good friends, by all means, and they should have immediate and direct communication. But the immediate supervisor of the recovery unit is the head nurse in the unit. She should be responsible to the surgical supervisor, who in turn is responsible to the director of nursing.

On the medical side we have a little different situation. There are two groups of doctors involved: the anesthesiologists and the surgeons. By and large, which one takes responsibility will depend probably on which has the more dynamic personality, but, in theory, at least, the anesthesiologist should be responsible for signing the patient out of the recovery unit. Until he says that the patient has recovered from anesthesia and his vital signs are stabilized, the patient cannot be discharged. In our recovery unit, the surgeon can order the discharge of his patient only with the concurrence of the anesthesiologist.

The chief anesthesiologist, on the other hand, can order the discharge of a patient from a recovery unit without the approval of the surgeon. He takes responsibility for determining the need to move patients out under pressure from new ones coming in, not the surgeon. The surgeon, after all, works on the individual patient; the chief anesthesiologist has to take a broader view of all the patients who have undergone anesthesia during each day.

The anesthesiologist also is responsible for the patient's position during the operation and postoperatively in relation to blood pressure and pulse — the patient's physiology — and, after all, it's the physiology we're most concerned with in the postoperative phase.

Postoperative group-nursing units have been successful everywhere. We also are proud of our results over the past two years. In over 8,000 operations in this unit, we've had only two cases of postoperative atelectasis, both of which occurred after the patients were transferred out of the postoperative unit into their own beds. We've had no deaths in the recovery unit from shock or hemorrhage or other complications that so frequently caused bad postoperative mortalities and morbidity when patients were cared for in their own rooms.

I don't mean to say we've had no postoperative deaths. But those that occurred were as a result of the impossibility of surgery preventing death in a fatal condition.

What about bringing T & A's into the postoperative recovery unit? We do. We have certain operating time during the week set aside for tonsillectomies, and the children come back into the recovery unit.

We've found it advisable, however, in the case of T & A's, to have nurses other than the recovery room nurses assigned to these children. They start with the children in their rooms before they come into the operating room. When the children are returned to the recovery room, the nurses are there to receive them and remain with them when they return to the ward. That doesn't mean that they supplant the postoperative nurses in the recovery unit, but they're with the children through the entire experience.

We take four to six or eight a day and handle them as a group. In our hands, at least, this has been a successful approach. The children stay in the recovery unit for about three or four hours, or until we are absolutely sure that no postoperative bleeding or hemorrhaging has occurred, and then they go back into their ward.

COMMUNICATIONS

I think the recovery unit should be in direct communication, by telephone, with every place in the hospital. We have two telephones. In addition, I think there should be direct intercommunication between the recovery unit and the central supply, the O.R. supervisor, the anesthesiologist's office, the doctors' and surgeons' lounge and dressing room, and the director of nursing.

If you really have an emergency, there should be some form of emergency bell or buzzer system that activates everybody in a hurry. That occasionally is necessary and ought to be included.

VISITORS

We do not allow visitors to the recovery unit until the operating schedule is over for the day. At 4 or 5 o'clock in the afternoon, visitors may be allowed in for just a few moments, *if* the patient has sufficiently reacted to make the visit desirable, and then only if he is in critical condition or is going to remain overnight. We allow them in for only a few moments at a time.

I think it's a good idea, if you can afford it and have the space, to have two recovery rooms. One should be smaller than the other and should be used for patients who might be visited for a period of time — those who are going to stay for a few days. Or you might have one or two glass-enclosed cubicles in the unit for that type of patient. If you have such a cubicle, access to it for visitors should be separate from the main access to the recovery unit, if possible.

Questions are often asked about the economics of the recovery room operation. I did a little calculating, in an effort to see whether we were losing or making money, and I'm happy to report: We're losing money. I'm one of those administrators who believe that unless a hospital is losing money it's not doing its job.

The way we work it, the first two hours in our recovery unit are part of the over-all care the patient gets on a flat-rate basis. If he stays longer than that, then we charge $2 an hour for a private patient and $1.50 for a semiprivate patient.

I've found that calculating income on that basis and comparing it with what it would cost to provide the same number of hours of special-duty nursing (if you could get it), we would lose $10,000 over a period of a year. I believe that's a pretty good price to pay for

(Continued on next page)

Surgical Nurse Section Meets At International College of Surgeons

Several sessions for surgical nurses were arranged in co-operation with the Operating Room Nurses' section of the Illinois State Nurses's Association at the recent International College of Surgeons meeting in Chicago.

Below: Phyllis Cockerill, operating room supervisor, Tampa (Fla.) Municipal Hospital, chats with Winifred Blanchard, hotel association hostess, Los Angeles, after panel session for surgical nurses.

Below: Mary Foley, clinical instructor, St. Xavier School of Nursing, Chicago, Bernetta A. Michels, O.R.S., Madison (Wis.) General, and Charlotte Cochran, Coldwater (Mich.) Community Hospital, chat with Bessie Hopping, O.R.S., Graham Hospital, Canton, Ill.

Above: Miss Hopping, co-chairman of the session for surgical nurses, speaks with J. M. de los Reyes, M.D., Los Angeles, California State Regent, International College of Surgeons after an afternoon session.

Above: Levis Duke, office nurse for J. M. de los Reyes, M.D. speaks with Marcella Fletcher, O.R.S., and Charlotte Hall, R.N., Jacksonville (Ill.) State Hospital.

Above: Lois Malkey, and Joan Larson, operating room nurses, Rockford (Ill.) Memorial Hospital, discuss some surgical problems encountered in their hospital with Margaret Young, O.R.S., South Chicago Community Hospital.

good postoperative care and for the kind of results we've achieved with it.

I'm sure that you could run a recovery unit and have it pay for itself, particularly if you didn't run it around the clock, seven days a week, 24 hours a day, and if you set your charges high enough. But when you begin to charge patients more than $2 for an hour's care in the recovery unit they begin to think, "What would it cost me to have a special-duty nurse?"

Obviously, on a per hour basis it would cost them less. But since they usually need only two or three or four hours of recovery room care and you can't hire a special-duty nurse for two or three or four hours (you've got to give her at least an eight-hour stint), the total cost would be a great deal more. But try to explain that to patients!

EQUIPMENT

First, you must have a utility room area or alcove, which should be equipped as completely as possible. If you have an adequate central supply, I do not believe you need sterilizing equipment, and I'd prefer not to have it. You should have a separate alcove with a bedpan-washer-sterilizer-flusher; heated cabinets for solutions as well as for blankets and linens; an adequate open storage and an adequate closed storage. I emphasize the need for open storage, because a lot of things should not be placed behind closed doors, even glass doors. They should be right out in the open when you need them.

You should have plenty of space for the storage of larger items of equipment: drainage, suction and intravenous equipment, and so on. You should have a biological refrigerator — one large enough to store blood prepared for a patient in advance.

We have a number of emergency trays that we keep as standard in our unit: a cardiac arrest tray; an intubation tray, with assorted sizes of endotracheal tubes, tongue depressors, a laryngoscope, and universal adapters; a tonsil hemorrhage tray; a tracheotomy tray; a thoracentesis tray; a cut-down tray; dressing sets; a stimulant drug tray with the usual drugs on it — caffeine, coramine, adrenalin, ephedrine, neosynephrine, ergotrate, crystodigin, digitoxin, sedatives, and so on.

Also standard items in the recovery unit are all current antibiotics; narcotics; intravenous vitamins B and C; all stocks of external solutions; all IV solutions (kept in storage); gloves, safety pins, clamps, connecting tubes, recipient sets, clysis sets, intravenous sets, head rolls, basins, tubular gauze, and iodoform packing.

The beds must have conductive rubber casters so that they can be used to take the patient directly off the operating table.

You'll need to include pillows in conductive rubber cases, emesis basins, towels, cloths, wipettes, and IV standards. We've been using the large ones on rollers, but I do think if somebody would design the proper kind of bed to which you could successfully attach an IV, that would be the preferable solution.

You need a number of portable suction machines. Even though you may have suction from the wall and your section in the wall should have adapters, you still need at least two portable suction machines, in case the wall suction doesn't work or in case you want a different type of suction. You need Wangensteen suction.

You should have two to four x-ray shadow boxes because the doctors will want to view x-rays in the unit.

You should have a sphygmomanometer *for every bed,* and you should mount it on the wall behind the bed, so it's not lost. Don't put it on a roll-away stand. Have a long enough tubing and cuff so that you could bring it to the patient. And by all means have children's cuffs and adult cuffs, and plenty of stethoscopes.

Nasal oxygen B.L.B. masks and all the rest of the equipment needed for oxygen administration, humidifier bottles and so on, should be standard equipment.

You'll want a resuscitator. We have two. One is a Stephenson — the one that sucks and blows and gives the combination effect — and for it you must have masks for adults and for children. Then we have a Pneophore resuscitator — the intermittent automatic positive-pressure type, used only with endrotracheal tubes in place.

You'll want assorted sizes of nasal airways, metal, plastic, and rubber, and endotracheal tubes, cuffed and plain.

Question and Answer Period

Q. Do you send all patients back to the recovery room, or are the spinals sent back to the floor?

A. We send all patients back to the recovery unit. In fact, in our set-up it works out that way anyway, because the entire operating suite is a "U" shaped unit. The patients enter in one corridor, go through the operating suite, and out through another one. In coming back through the second one they have to go past the recovery unit, and it's natural to take them right in.

Q. Do you prefer beds to cots?

A. If you mean stretchers, I have yet to see a stretcher that in my estimation is quite adequate. We are trying out a new one which is a little wider than the standard stretcher. If the stretchers do work out, they're an advantage, because they don't take so much space.

It's important to think in terms of "one movement only" off the operating table. You should check to make sure that the operating table has sufficient elevation, so that when you get in the right position the table is exactly the same height as the bed you're using.

Q. If a patient has a private nurse, is he taken to the recovery room?

A. He certainly is! We do not believe that the usual private-duty nurse is trained to postoperative nursing care, at least in the initial phases. We allow the private-duty nurse to remain with the patient in the recovery unit. But she takes her orders from the head nurse of the recovery unit during that time. Sometimes she's very useful, particularly when they get very busy.

Q. Do you use restraints?

A. We use sideboards or side rails. In recent years, the quality of preoperative medication and of anesthesiology is so high that the number of patients who need to be restrained is much less than it used to be. I think it will probably become even less as time goes on.

Q. Where do we place the head of the patient in the recovery room?

A. Toward the wall, so that the nurses, in circulating, are looking at the patient's face, and not the top of his head. That also is the end of the bed that has the low headboard. Actually our headboard and tailboard are the same height, and both are low. But if you have a high headboard you should turn it around and place the patient against the tailboard.

Q. If the patient is retained for a number of days in the recovery room, is the routine room charge eliminated?

A. Ordinarily, no. But every time the problem comes up, if it's a semiprivate or a service patient I'm sure to get a request from social service or from the family for reduction of charges, and so I usually cancel it. It's a double charge and much too expensive for most people. But as a matter of policy we have not eliminated it. I think such a move might stimulate the doctors, under certain circumstances, to keep people in the unit to save them money, and that isn't good hospital economics.

Q. How many patients should a nurse take care of at one time?

A. During the busy hours of the day we always have at least one head nurse, two R.N.'s, one volunteer, and one aide in attendance. So at times we have five people taking care of eight to ten patients. But I think the minimum is: four patients, one R.N., and one aide.

Q. Do you handle outpatients without having a room on the floor assigned?

A. Yes. We admit patients for ambulatory surgical procedures, as long as they do not involve general anesthesia or spinal anesthesia. Sometimes those patients will stay for a few hours and return to their homes without being sent to a room.

In order to achieve the most comfort under those circumstances, we have, in addition to our postoperative recovery unit, a separate recovery room, located in a slightly different area from the major operating facilities, although it is on the same floor and in the same suite. It's right next to a minor operating unit in which we do most of our endoscopies.

This little room is fitted out as a sort of waiting-room. It has a nice cot, a table, a chair, a lamp, and reading material. Patients will spend an hour or two there after a procedure before they go home. A paper written recently by a British surgeon told of doing herniorrhaphies on children in the outpatient department on an ambulatory basis and sending them home, and getting as good results as when patients are admitted to the hospital.

Q. Do you send cesarean sections to the recovery room?

A. No. Our cesarean sections are not done in the operating suite. Our delivery unit has three delivery rooms, all of which are fitted out and equipped for major surgery. One of these is designed specifically for cesarean sections. When we planned that unit, we did not plan an O.B. recovery room. Since then we've had requests from the house physician for an O.B. recovery unit, and we're planning one.

Q. What do you think about having the recovery room as part of the student's teaching program?

A. I think that you couldn't have a better unit for teaching purposes anyplace!

—

Evanston Hospital Finds Burn Packs Valuable Time-Savers

• Special burn packs, autoclaved as a unit, are kept on hand for o.r. use at St. Francis Hospital, Evanston, Ill. Appropriate dressings for burn victims are always instantly available.

Two or three packs of varying sizes are autoclaved each week. When a dressing is to be applied, the magnitude of the burn is determined, and an appropriate pack opened. All burn dressings are done in the operating room.

At right is a typical burn pack. It contains: doctor's gowns; 3" rolls of fine mesh roller gauze; 4"x4" gauze dressings; five yard course mesh gauze rolls; elastic bandages; rubber gloves; sterile towels; sterile drapes; large dressing pads (Abd. type). Vaseline gauze, also used on occasion, is obtained separately.

In emergencies, burn packs such as this save much valuable time. They are particularly recommended for children's hospitals and pediatric units, since the majority of burn victims are children.

The O.R. Problem Clinic

by EDITH DEE HALL, R.N.

First Speakers Announced For A.O.R.N. Conference

The fourth annual conference of the Association of Operating Room Nurses, to be held at the Hotel Statler, Los Angeles, February 18-20, 1957, will feature outstanding speakers who will discuss all aspects of operating room problems and procedures.

Among the subjects definitely scheduled are hypothermia in surgery, sterilization of supplies, value of the postanesthesia unit in patient care, operating room "headaches"—including on-call and overtime, schedules, and the "problem surgeon"—operating room training in the nursing curriculum, and purchasing directly from the manufacturer.

These and many other excellent lectures and discussions will provide a practical program that meets the specific needs of operating room nurses.

The program so far is as follows:

Monday, February 18:
8:30-11 a.m.

There will be three programs running concurrently every morning. In the Golden State room on the opening day, there will be a panel on "Looking into the Future for Operating Room Nurses." Subjects and speakers are: "The Licensed Vocational Program." Nina B. Crafts, R.N., director of nursing service and education, Los Angeles County General Hospital; "The Student Nurse Viewpoint," Mary Louise Steinke, president, National Student Nurses' Association, Kaiser Foundation Hospital, Oakland, Calif.; "The Two-Year Program," Dorothea Daniels, R.N., administrator, Kaiser Foundation Hospital, Los Angeles, and chairman, nursing education advisory committee, Los Angeles City College; "The Degree Program," Mrs. Lulu Hassenplug, R.N., director of nurses, UCLA Medical Center; "Looking Ahead," Col. Inez Haynes, chief, Army Nurse Corps, Office of the Surgeon General, Washington, D.C.

At the same time, in the Los Angeles Room, there will be a lecture on "Surgery of the Newborn," by surgeon William Snyder, Jr., M.D. and anesthesiologist Digby Leigh, M.D., both of Children's Hospital, Los Angeles. This will be followed by a discussion on "The Use of Art in the Operating Room," by J. Howard Payne, M.D., associate clinical professor of surgery, UCLA School of Medicine, Los Angeles, and medical artists Ted Bloodhart and Mrs. Gregg Moris, from Good Samaritan Hospital, Los Angeles.

Another program will be held in the Wilshire Room. Subjects and speakers will be announced in the near future.

3-5 p.m.

"Disaster Day" is the theme of this session, the program for which is being worked out by Los Angeles civil defense authorities.

Tuesday, February 19:
8:30-11 a.m.

"Headaches in the O.R." is the theme of the program in the Golden State room. Mary Sylvia, R.N. superintendent of nurses, Camarillo (Calif.) State Hospital, will be moderator of the panel. All participants will be experienced operating room nurses. Subjects will be "On Call and Overtime," "Schedules," "Apathy and Absenteeism," and "The Problem Surgeon."

The second session, in the Los Angeles room, will present, first, a lecture on "Surgical Rehabilitation in Relation to Fractures," by Alonzo Neufeld, M.D., White Memorial Medical School, Los Angeles. Darrell L. Gifford, manager, technical sales division, American Sterilizer Co., Erie, Pa., will speak on "Purchasing Directly from the Manufacturer," and Earle Boehme, M.D., Santa Monica (Calif.) Hospital will discuss a new adrenal tumor.

"The Postanesthesia Unit—Value in Patient Care" will be the opening lecture at the morning's third session, in the Wilshire room. Speakers will be James S. West, M.D., anesthesiologist, and Mrs. Joyce Stromquist, R.N., both from Daniel Freeman Memorial Hospital, Inglewood, Calif. They will discuss orientation, visual aids, supportive measures, and positioning.

Robert W. Virtue, M.D. professor of anesthesiology, University of Colorado School of Medicine, Denver, will speak on "Hypothermia in Surgery." Dr. Virtue is the author of *Hypothermic Anesthesia* (C. C. Thomas, publisher).

3-5:30 p.m.

The afternoon program will be devoted to a panel on sterilization of supplies. Moderator will be John Gabel, Wilmot Castle, and participants will be J. Hamilton Scott, American Sterilizer Co.,"Saturated Steam"; Richard E.

(Continued on next page)

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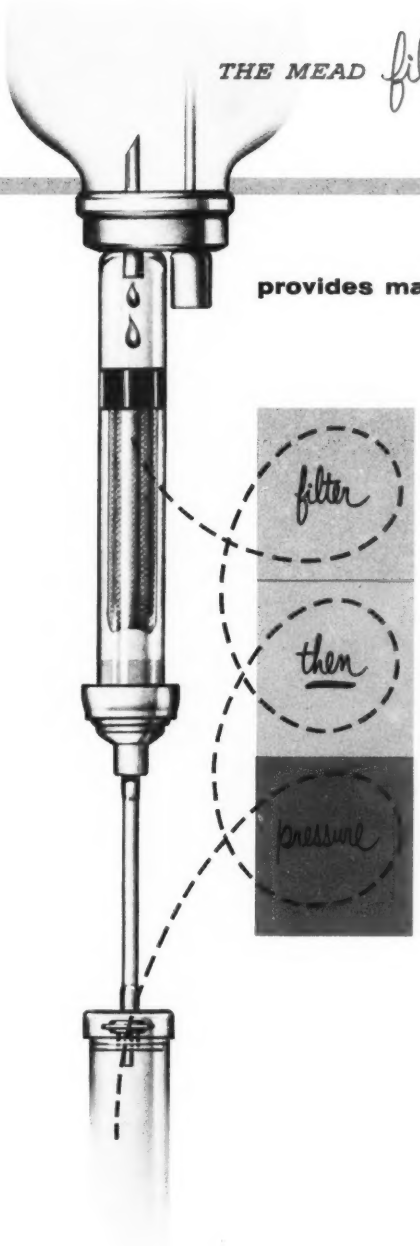

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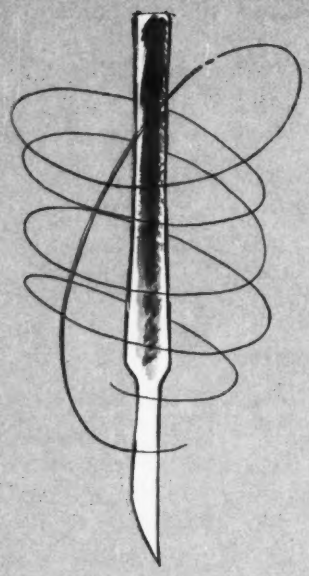

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Recognition of the surgical patient's special needs for nutritional support has resulted in many advances in the science of nutrition.[1]

In a recent editorial summarizing nutritional factors in surgery, Ravdin[1] called particular attention to the malnourished patient's:

susceptibility to shock during anesthesia and operation

tendency to liver damage

delay in wound healing

susceptibility to infection

Ravdin[1] also suggests that in the absence of frank signs of deficiency it is nevertheless reasonable to assume that deficiency exists whenever illness has been prolonged, particularly in the face of faulty dietary intake.

1. Ravdin, I. S.: Symposium on Nutrition in Surgery, Editorial, Am. J. Clin. Nutrition 3: 447-448 (Nov.-Dec.) 1955.

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Burgess, director of control, Don Baxter Co., "Sterilization by Gas"; C. A. Lawrence, Ph.D., director, bureau of laboratories, Los Angeles Department of Health; and Emil G. Klarmann, Ph.D., vice-president, Lehn & Fink Products Corp. The speaker on "Dry Heat" will be announced later.

Wednesday, February 20:
8:30-11 a.m.

"Surgery of the Hand" will be discussed by J. H. Boyes, M.D., Los Angeles, in the session in the Golden State room. Dr. Boyes will emphasize preservation and reconstruction, with nurse participation, and will demonstrate special drapes. The second speaker at that session will be James E. Ludlam, Los Angeles, legal counsel, California Hospital Association, who will talk on "The Need for Malpractice Insurance for Operating Room Nurses."

W. Mikkelson, M.D. Centinela Valley Community Hospital, Inglewood, Calif., will talk on "Cardiac Arrest" at the session in the Los Angeles room. His lecture will include visual aids, equipment, medications, and trays.

"Fires and Explosions in the Operating Room" will be the subject of the other lecture at that session. The speaker will be announced next month.

Program for the session in the Wilshire room will also be announced in the near future.

3-5 p.m.

The ever-popular "Problem Clinic" will be presented at the final conference session. Moderator will be J. Norman O'Neill, M.D., president, Los Angeles County Medical Society. Participants thus far include: Director of nurses —Nina B. Craft, R.N., Los Angeles; anesthesiologist—Forrest Leffingwell, M.D., College of Medical Evangelists, Los Angeles; operating room supervisor—Sister Patricia, Charity Hospital, New Orleans; and hospital representative and former administrator—Jack Fulton, Los Angeles.

Thursday, February 21:

The day following the conference has again been designated as "Hospital Day," and programs are being planned for visiting nurses in local hospitals.

Look for further details and announcements of local planning committees in the November issue of HOSPITAL TOPICS.

Antistatic Tile Given U.S. Patent

A patent for an antistatic tile and the method for making it has been assigned by the U. S. Patent Office to the Commonwealth Engineering Co. of Ohio, Dayton, O.

The tile is intended for the walls and floors of any space where there are explosive vapors such as gasoline, ether, or similar materials. It can be used in hospital operating rooms, dry-cleaning shops, garages, pharmaceutical plants, and powder works.

A nonflammable base, such as rock wool or glass fiber, is coated with a film of metal that permits the discharge of static electricity. In the manfacturing process, minute "discharge points" are raised on the metal surface, allowing the harmless discharge of static.

The patent notes that ". . . Some progress has been made . . . by the use of carbon-black, but the difficulty has been that this reduces the light reflecting characteristics and the sanitary appearance and other characteristics desired in tile of this character."

Commonwealth Engineering Co. of Ohio, an industrial research organization, does not manufacture products. However, it grants licenses to manufacturers who wish to produce products under Commonwealth patents.

HYPOTHERMIC ANESTHESIA. **By Robert W. Virtue, M.D.,Ph.D., Associate Professor and Head of Anesthesiology, University of Colorado School of Medicine, Denver, Colo. Published by Charles C. Thomas, Springfield, Ill. 62 pp. $2.50.**

Since there are so many problems yet to be answered and the whole field is developing so rapidly, this book should be taken as an interim report of the status of hypothermia, the author says.

The book contains chapters on the early observations of the use of hypothermia on animal and human beings and on recent observations of physiological effects in animals. Clinical experiences and complications are covered. An outline of present clinical procedure and future developments brings the reader up-to-date in the work so far developed in this field of anesthesia.—**Muriel Dow, R.N.**

O.R. QUESTION BOX FROM HOSPITAL TOPICS. **By Carl W. Walter, M.D., Published by Chicago: HOSPITAL TOPICS. 1956. 64 pages. $1.00.** Here are answers to 195 of the most frequently asked questions concerning operating room procedure and technic, given by a leading authority on aseptic technic. Dr. Walter, associate clinical professor of surgery, Harvard Medical School, and author of **Aseptic Treatment of Wounds** (Macmillan), each year conducts a number of popular operating room institutes at leading medical centers across the country.

The questions in this book were compiled from Dr. Walter's column in HOSPITAL TOPICS. The pocket-sized volume is a valuable reference book for O.R. supervisors, nurses, and other staff members, as well as a useful guide for those just entering the field.

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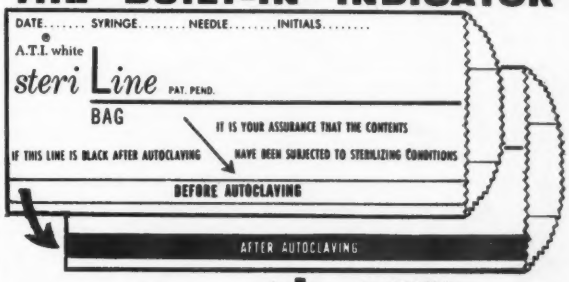
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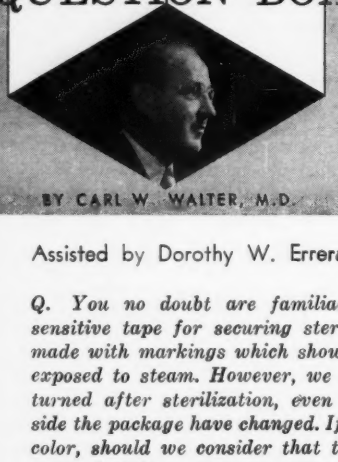

BY CARL W. WALTER, M.D.

Assisted by Dorothy W. Errera, R.N.

Q. You no doubt are familiar with Scotch pressure-sensitive tape for securing sterile packs, etc. It is now made with markings which show when the tape has been exposed to steam. However, we are finding a lot has not turned after sterilization, even when Diack controls inside the package have changed. If the tape has not changed color, should we consider that the package has not been exposed to the proper temperature?

A. I would evaluate the technic of loading the sterilizer to make sure packages are not packed tightly and would rely on the thermometer in the discharge line to indicate when a lethal concentration of steam is filling the chamber. Timing for 30 minutes after this exhaust line temperature reaches 250° F. exposes the contents of the sterilizer to a microbicidal concentration of steam.

If the sterilizer is loaded so that there is a free exchange of air and steam, I would consider its contents sterile after this exposure and reason that the tape is perhaps from an imperfect lot.

Q. Please send me a list of timing for autoclaving of the various articles in the operating room. We would also like to know the time autoclaving is effective and when it should be repeated.

A. In the interests of patient safety and economy, a standardized sterilizing time of 30 minutes at 250° F. is chosen. This allows for adequate penetration of the largest pack sterilized, plus the thermal death time of resistant spores, plus a factor of safety. With proper hydration of textiles, suture material, etc. before sterilization, this time is not unduly destructive of supplies.

Once wrapped in four thicknesses of muslin, positioned properly in the sterilizer, exposed to saturated steam at 250° F. for 30 minutes, and stored in a clean, dry, vermin-free place, supplies remain sterile until used. Resterilization is destructive of materials and a waster of personnel time.

Q. Would the following method of cleaning and sterilizing IV tubes be considered adequate and safe? The tubes are washed in a detergent solution without being disassembled and remain soaking in that solution for 15 minutes and then are rinsed in distilled water.

Then, after drying, the tubes are wrapped in a towel and sterilized in a small sterilizer, the latter being filled with a small amount of tap water. The tubes are left in for 15 minutes. They are then removed and placed on the top of the sterilizer to dry, since they are a little damp after the above process.

These plastic tubes are being used over and over until they are useless. They are used interchangeably for IV infusions and blood transfusions.

Would it be better if they were left soaking in distilled water for four hours disassembled and then wrapped and sterilized in the autoclave? Is there a better method of taking care of IV tubes?

A. There is such a variety of expendable infusion sets available today that I doubt whether you can justify the expense or inconvenience of processing your own.

The apparatus used for IV infusions and transfusions is vitally important, and soaking it as you describe is a hazard, inasmuch as bacteria will grow in the residual solutions and blood and produce pyrogens which are difficult to remove. In the interests of personnel and patient safety, tubing contaminated with blood is discarded because of the virus of homologous serum jaundice which is transmitted by handling such contaminated equipment. Glass filter chambers, dripchambers and narrow lumened adapters are very difficult to clean adequately and represent the source of many pyrogen reactions in patients receiving infusions and transfusions. They should be cleaned with a hot detergent solution; flushed through with the same solution and rinsed copiously with distilled water and dried by suction. The set is assembled and rinsed with distilled water immediately before sterilization. It is wrapped in 4 thicknesses of muslin and sterilized at 240° F. for 30 minutes. It should be dried for 3 days before use.

Q. We have recently started mopping our terrazzo floors in the operating rooms with Clorox to reduce static electricity hazards in surgical areas. We would like to know whether Clorox can be used exclusively as a disinfectant on floors, walls, and furniture in surgery to effectively eliminate all types of bacteria found there.

A. Sodium hypochlorite (Clorox) contributes nothing to the safety of the operating room floor from the standpoint of eliminating explosion hazards. The moisture provided in mopping the floor renders the floor temporarily conductive as long as it is wet. Once dry, that conductivity is lost unless the floor is inherently conductive. Sodium hypochlorite 1:1000 is a good disinfectant for the uses you describe.

Q. Is it necessary to oil the joints of all instruments, even those which are not used but autoclaved? Isn't it true that if the joints are not wiped, the steam will eventually leave a mineral deposit and if rust or corrosion has started, it will spread before it can be checked? If all the joints are to be oiled after each use, are the ones not used also oiled? This topic has caused quite a bite of dissension, and the sooner we get it cleared up the better working conditions will be.

A. With proper cleaning, sterilization, and storage, instruments need no oiling. Oiling introduces a hazard in that the film present protects bacteria trapped beneath from contact with steam in the sterilizer.

Oiled instruments are only adequately sterilized in an instrument-washer-sterilizer, which removes the film of oil and exposes all surfaces of the instruments to moist heat. Instruments do not corrode as a result of sterilization. They corrode from inadequate drying, being stored while wet, or being stored in excessively humid areas.

Instruments cannot be cleaned manually and cannot be dried manually. The former requires mechanical devices with proper detergents to thoroughly remove deposits of blood and dirt which otherwise bake onto the instrument in the sterilizer. It is impossible to dry the many crevices and locks on an instrument, and if a drying cabinet is not available, instruments should be dried in an ordinary dressing sterilizer with steam in the jacket but not the chamber. In humid climates, the addition of a "damp chaser," such as is used in pianos, to the instrument cabinet will minimize corrosion. These dehumidifiers are heating elements encased in rods; they run on ordinary current and keep the cabinets dry.

(Continued from page 96)

the team. It is felt that the fewer people handling the blood, the less likelihood of error.

After starting a transfusion, the nurse remains at the bedside for five minutes to watch for reaction. At least three times during the course of the infusion, she returns to the bedside to check on the patient. If a reaction does occur, the blood is discontinued, and saline is allowed to drip slowly until the physician arrives.

A new sample of the recipient's blood is returned to the laboratory with the blood causing the reaction. A transfusion history book is kept in the blood bank with a record of all drugs added to the bloods, reactions, etc. The reaction rate has dropped from eight percent in 1949 to 1.4 percent in 1955.

The department maintains all equipment associated with intravenous therapy, including exchange transfusions and venesections. Each new group of interns, residents, and nurses is oriented to the use of the equipment. Each group of freshman nurses has six hours on the nursing care of the patient receiving intravenous therapy. Skills in the team are developed by repetitions. The results are more efficient use of time and effort on the part of the staff and more skillful and safe infusions for the patient.—**Virginia B. Foote, R.N., White Plains (N. Y.) Hospital.**

Test Various Methods For Plasma Sterilization

BPL Considered Best

After a study of the virucidal activity in vitro of 600 agents against a variety of viruses, only four were thought to warrant further evaluation — B-propiolactone, ethylene oxide, butylene oxide, and sulfur mustard. The narrow margin of safety between the virucidal concentration and the toxicity concentration eliminated the latter two.

Each chemical agent was evaluated in terms of its ability to react with specific viruses involved, and any compound was not considered finally evaluated until tested directly against the hepatitis agent. Sulfur mustard was as effective as BPL but more toxic. The plasma proteins also appeared to be affected.

Hence the drug of choice appeared to be BPL (B-propiolactone). While very toxic in undergraded lactone form, it hydrolyzes rapidly in water and plasma to nontoxic compounds. After treatment of plasma with BPL, none of the original drug is found to be present.

To obtain consistent results in sterilization of plasma, as little drug as possible is used. This results in less acid neutralization and a minimal alteration in the plasma proteins. The lower the protein content, the less drug needed. The lower the virus titer, the lower drug concentration needed.

Plasma treated with BPL is not toxic to man, but the concentration should be limited to 4,500 mg.L.

While this concentration is satisfactory for most laboratory viruses, it may not be sufficient for traces of hepatitis virus; so a combination of BPL and other agents was evaluated. Ultraviolet radiation appears to be most promising. The effect of its combination with BPL is apparently synergistic in virucidal action without increased alteration of protein constituents. — **Frank H. Hartman, M.D., Consultant in Pathology, Henry Ford Hospital, Detroit, Michigan; Medical Research Advisor, U.S.A.F., Washington, D. C.**

(Continued on next page)

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General problems in management of the acute radiation syndrome include the use of antibiotics and transfusion therapy. It is recommended that no antibiotics be given prophylactically. They should be given only if infection develops that would be treated with antibiotics anyway. They should be withheld as long as possible because of the resistance developed by bacteria.

In a major catastrophe, in which widespread empirical use of antibiotics might be unavoidable, it is recommended that an oral antibiotic with a wide spectrum be used. Tetracycline appears to be desirable for this purpose.

Blood transfusion should never be used prophylactically. Fresh, whole blood collected in plastic bags or platelet transfusions has some value in controlling purpura and spontaneous bleeding.

The use of drugs without clear-cut indication should be discouraged because of the deranged metabolism of the burned patient. There is no specific prophylactic or therapeutic agent to be stockpiled for use in depression of hemopoiesis—**Eugene P. Cronkite, M.D., Upton, N. Y.**

List Program Purpose Of Joint Blood Council

Plan Blood-Collection Depots

The Joint Blood Council, Inc., has as its purpose the development of ways and means to make blood and its derivatives available to all people in the country. It is intended to stimulate and advise on research involving the preservation of blood and its derivatives. It intends to establish minimal standards for qualifications of blood banks. It will not procure blood and will not process blood. All policies are determined by the board of directors, comprised of representatives from each of the five constituent organizations.

The council will establish blood-collection depots in times of disaster in communities in which they do not exist. This program is now the responsibility of the Red Cross and private blood banks, by agreement with the federal government.

An attempt is being made to discourage the terming of blood as a "commodity" — the cost of which is reimbursable. The selling of blood for profit is discouraged. A service charge to the recipient should include all costs involved in processing the transfusion but should not include a profit.

Ideal blood-banking procedures to insure safety for the recipient will be developed, and minimal standards for voluntary accreditation will be outlined.

A nationwide survey of blood banks and the ultimate publication of a directory are planned. The American Association of Blood Banks has representatives in every state to assist the council in screening blood banks for inclusion in the directory. It is hoped that a centralized, impartial clearing-house of information will be available to get rid of misinformation, to educate the public, and to develop good public relations, and also that a national clearing-house for exchange of blood and credits between various systems can be developed. — **Frank Wilson, M.D., Executive Vice President, Joint Blood Council.**

(Continued on page 133)

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Procedure Manual No. 2, by Alice L. Price, R.N., M.A., author of "The Art, Science and Spirit of Nursing," explains in detail the many different uses of the Hill-Rom Special Therapy—Labor-Recovery Bed, how to use and care for the bed, etc. Copies for student nurses and graduate nurse staff will be sent on request.

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The Book Corner

Sterilization Book

PRINCIPLES AND METHODS OF STERILIZATION. **John J. Perkins, M.S. Published by Charles C. Thomas, Springfield, Ill. $8.00.** This informative book of 334 pages will be of interest to the key persons responsible for sterilization technics in hospitals—particularly operating room supervisors and central supply supervisors.

The basic principles upon which conventional sterilization process depend are detailed. Practical methods for preparation and sterilization of supplies, plus a reference guide for sterilization practices in hospitals, clinics, laboratories and allied institutions and services are described.

Consideration is given by the author, after a brief historical introduction, to the following: Thermal destruction of microorganisms, principles of steam sterilization (advantages and disadvantages) minimum standards of sterilization, modern surgical sterilizer, preparation and sterilization of dressings, dry and rubber goods, and surgical instruments. Water sterilizers and dry heat sterilizers, the disinfecting of instruments by boiling water, the processing and sterilization of syringes and needles are covered.

Trends, Statistics Included In New Reference Book

HOSPITAL TRENDS. By Louis Block, Dr. P.H. Chicago: HOSPITAL TOPICS. 1956. 224 pp. $5.00. This book is designed as a handy reference volume for trustees, administrators, department heads, or hospital administration students.

There are three sections. The first contains chapters analyzing changes which have occurred in U.S. hospitals in the last 20 years — in size, average length of patient stay, bed occupancy, census, admissions, personnel, income and expenses, rates and other major areas.

The second section, containing facts on the average hospital, correlates statistics on facilities, personnel, and finances for every major type of hospital. The third section, on "Management and Planning Mechanisms," presents practical information on financial support for maintenance and operation, controlling expenditures, budget, and cost analysis.

The author is chief, research grants branch, Division of Hospital and Medical Facilities, U.S. Public Health Service, Washington, D.C.

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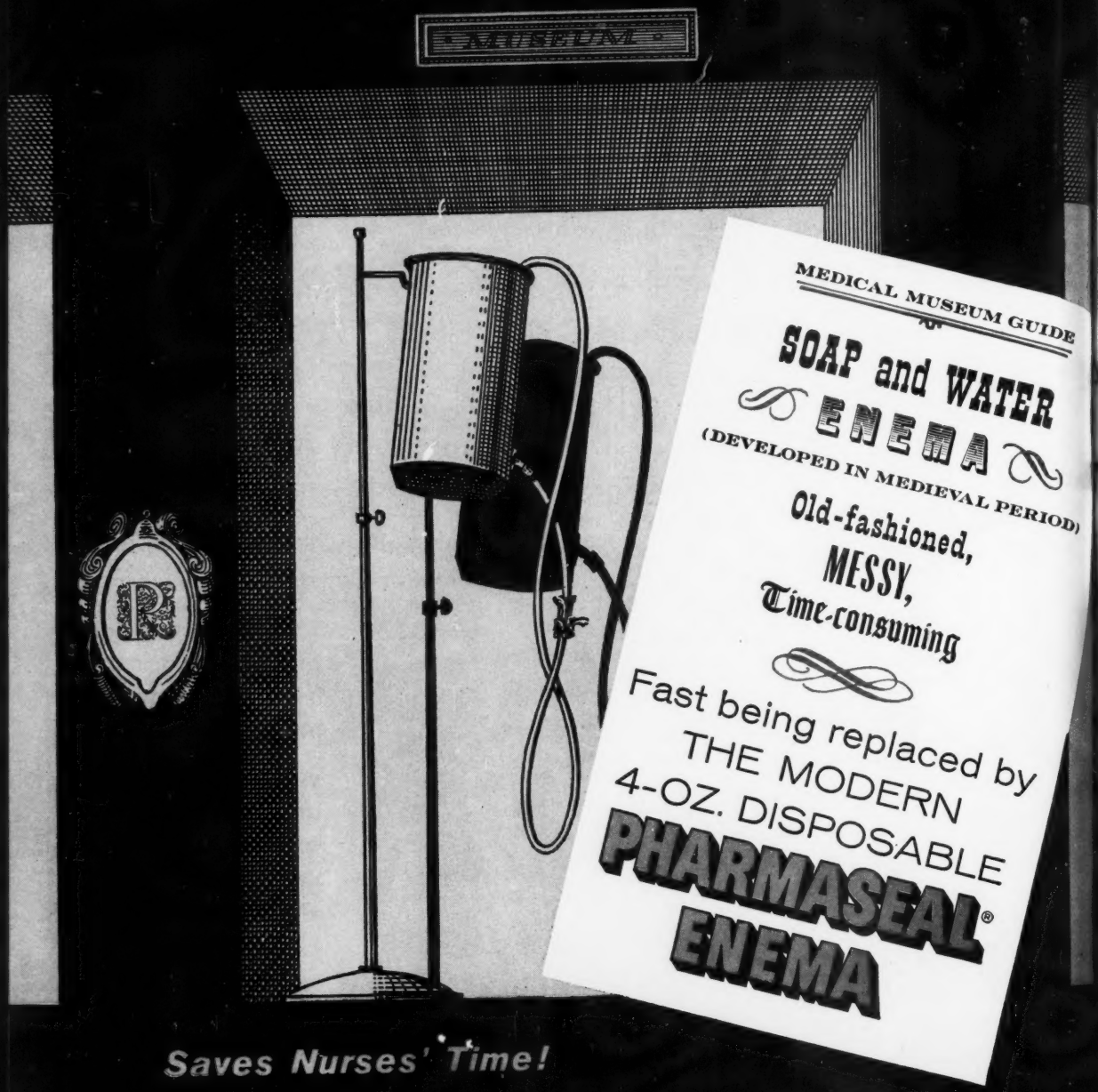

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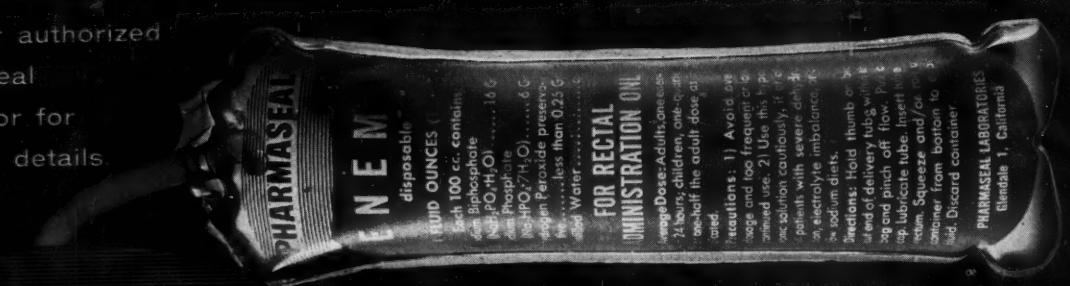

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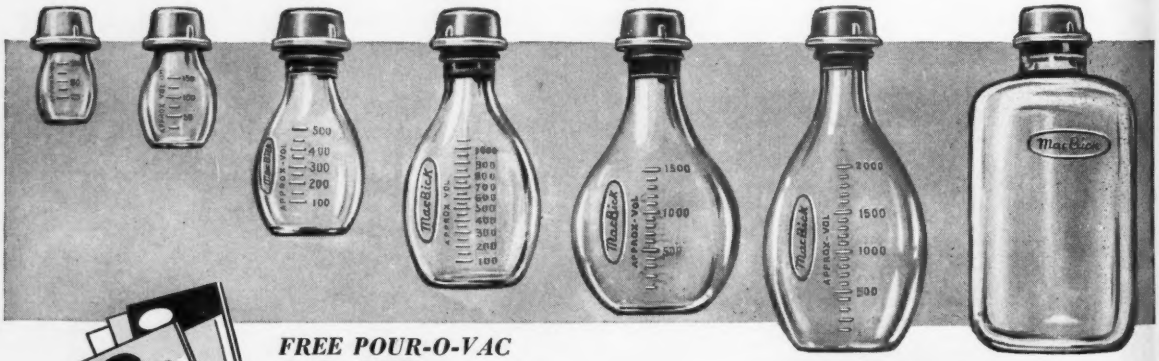

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Central Supply Room Staff

contributions are welcome

The Administrator Evaluates Central Supply

By Norman D. Bailey*

The following article was written especially for the CENTRAL SUPPLY YEARBOOK from HOSPITAL TOPICS (Volume I). Copies of this yearbook are now available (price: $1.50).

EXPERIENCE in a hospital which for several years has maintained an efficient and well-organized central supply service, preceded by experience in hospitals in which central supply service was either extremely limited or nonexistent, provides a fair basis for evaluation of the effectiveness and desirability of such a program.

In a large degree the weight of the evidence is in favor of a central supply service. This favorable balance could be upset, however, if certain basic and essential conditions should be lacking. As one of America's largest industries, hospitals must, of course, stand committed to efficient and sound business operation. It is even more important that their procedure contribute to the improvement of patient care.

From the administrative point of view, any planned coordination of effort that (a) increases productivity; (b) provides for better utilization of manpower; (c) leads toward more economical operation; (d) decreases time lapse between need and availability, and (e) develops better understanding of responsibilities, should lead to better patient care.

A well-planned central supply unit increases productivity. Through elimination of duplication, it is possible to operate with fewer units of each instrument or other needed items, yet, because of this reduction, to provide for a more widespread selection at no increase in cost.

A well-organized central supply unit lends itself to optimum utilization of personnel. Such utilization is attained when each employee finds himself occupied to the full extent in that work for which he is best trained and for which he has the most aptitude.

Too often in our modern hospitals we are forced to employ a skilled individual for some particular task, only to find that he can be utilized at his highest skill for only a small portion of working time, while the balance of his time is spent in working at some lesser skill for which less money might have been paid. Opportunity is afforded in a centralized plan to train this employee to do specific tasks and to perform them with sufficient frequency to acquire skill and relatively high productivity.

Experience has taught us that only when a task is performed with sufficient frequency is that task performed economically from the standpoint of method, time, or material. Such a possibility is less apt to be present when the decentralized program is in operation.

For each position in the central supply unit, position specifications and procedure sheets can be developed. Through these, better selection and recruitment of employees can be carried on by the personnel department. Savings in the number of employees may make available money which can be utilized to increase the pay schedule and make recruitment more selective.

Such possible savings may not be apparent at first, since the employees who formerly performed the tasks will still be on the payroll and will be needed to perform the balance of their individual work schedules. As the program is developed and each individual job of which the content has been changed is restudied, new assignments of tasks will remedy the situation, and the savings will become apparent.

Increased definitiveness of task — spelling out responsibilities of the individual employee—makes supervision easier and helps for clearer understanding between supervisor and employee.

Whereas in a decentralized unit a supply nurse may be required in each area, the centralized plan should make it possible to employ skilled nurse supervision and a balance of nonprofessional-level-employees. This will produce savings and may lead to better job satisfaction on the part of the employee group.

Very important in the picture is the unit supervisor who becomes a specialist in her area of work. She is available for consultation with members of the medical staff, of whose special interests and needs she has become cognizant. She should meet with whatever committee of the medical staff is concerned with medical supplies and equipment. She should become so skilled in her field that she provides basic assistance to administration in interpreting the needs of

(Continued on next page)

*Executive director, Grant Hospital, Chicago.

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—QUANTITY PRODUCTION; STANDARDIZATION OF EQUIPMENT

It is an axiom of administration that an increase in the quantity of production should mean lowered cost, improved service, and increased efficiency. The cost of basic equipment is reduced to a minimum through elimination of duplication of equipment. In a decentralized program the necessity for availability of items which might just as easily be placed in a central supply unit means purchase and maintenance of several units of the same item.

Through the medical staff's therapeutic or surgical committee, agreement can be reached as to desirable standards for each unit handled by the central supply service. Here again the special training of the supervisor becomes significant. The contents of the various packs can be determined.

Since these packs or units are all set up under standard directions and trained supervision, the possibility of misinterpretation of directions and of substitutions of other than specified items is reduced to a minimum.

—ECONOMY OF OPERATION

Economies through increased productivity and through better utilization of personnel can lead to savings or to possible increase in the money available for equipment. Another outgrowth of a good central supply program should be the increase in the variety of equipment which can be justified. Money saved may well be used for this purpose.

—SUMMARY

Administrators may well view a centralized supply service as a basic factor in a smooth-running hospital. Regular reports as to its services should be made to the director of nursing and the administrator. With such reports at hand, the administrator is able to back the department and explain problems brought to him. If personnel are well chosen, he can feel a sense of certainty that the department is administered in the interests of the best possible care of patients.

Guide to Central Supply Literature

Supplement No. 2

(The following supplement is reprinted from HOSPITAL TOPICS' CENTRAL SUPPLY YEARBOOK, Volume I)

Anderson, Mary Helen. "Setting Up a CSR Procedure Manual." *Hospital Management*, January 1954, Vol. 77: pp. 60+; February 1954, Vol. 77: p. 65; March 1954, Vol. 77: pp. 74-76; April 1954, Vol. 77: pp. 76-82; May 1954, Vol. 77: pp. 80-82+; June 1954, Vol. 77: p. 66; July 1954, Vol. 78: p. 66.

The articles in this series describe a method for setting up a CSR procedure manual which will be valuable as a workable guide to CS personnel. Samples of forms included.

Anderson, Mary Helen. "Central Service—A Challenge." *Nursing Outlook*, December 1955, Vol. 3: pp. 655-656.

The growth of central supply to a service center for the entire hospital is told in this article, which points out that the full potentiality of this department has only recently been recognized by nursing service administrators.

Anderson, Mary Helen. "Defining the Clerk's Role in Central Service." *Hospital Management*, March 1955, Vol. 79: pp. 78-79.

The tasks that are listed may be effectively handled by a clerk to aid the supervisor. These include answering the telephone and following up on missing items.

Anderson, Mary Helen. "Five Steps to Guide You in Evaluating New Products." *Hospital Management*, January 1955, Vol. 79: pp. 74 and 85.

The author gives five specific steps to guide the supervisor of central supply in evaluating new products. A filing card system is suggested to simplify the tabulations of results and interpret the findings.

Anderson, Mary Helen. "How Safe Is Your CS Department?" *Hospital Management*, June 1955, Vol. 79: pp. 74-75.

A check list of suggested safety habits for a central supply department to keep on file is given in this article. The list includes safety measures for the patient, visitors, and personnel in central supply and other departments.

Anderson, Mary Helen. "Safety, Efficiency, and Economy." *Hospital Management*, December 1955, Vol. 80: pp. 78-80.

The author suggests how equipment that has outlived its usefulness may be utilized for something besides the purpose for which it was designed. An example: Plastic tubing fastened to adhesive to aid in holding dressings in place.

Anderson, Mary Helen. "Setting Up a Pick-Up and Delivery Service." *Hospital Management*, April 1955, Vol. 79: p. 49.

The need for this type of service and the procedure for establishing it are given in this article. A suggested schedule is included.

Anderson, Mary Helen. "Solving Those Disagreeable Problems." *Hospital Management*, October 1954, Vol. 78: pp. 75-76+.

An article describing the expansion of central service and the establishment of standards to meet the additional functions.

Anderson, Mary Helen. "The Administrative Structure of CS." *Hospital Management*, February 1956, Vol. 81, pp. 90 and 105.

Various methods used for central service administration are discussed in this article, including supervision by nursing service, by the operating room, or by a department head who is not a nurse, such as a pharmacist, or by someone directly responsible to the hospital administrator.

Anderson, Mary Helen. "The Case for the Dressing Tray." *Hospital Management*, August 1955, Vol. 80: pp. 70-71.

The author questions the efficiency of the dressing cart, since many items are used infrequently, and contamination results from many exposures. The advantages of dressing trays dispensed by central service with the correct and needed items for each dressing are presented.

Anderson, Mary Helen. "Training CS Personnel to Handle Oxygen." *Hospital Management*, December 1954, Vol. 78: pp. 75-76+.

The author describes the various methods for instructing central service personnel in the handling of oxygen, such as the use of manuals, films, and actual demonstration of the use of equipment.

Anderson, Mary Helen. "What Makes a Good Supervisor." *Hospital Man-*

(Continued on next page)

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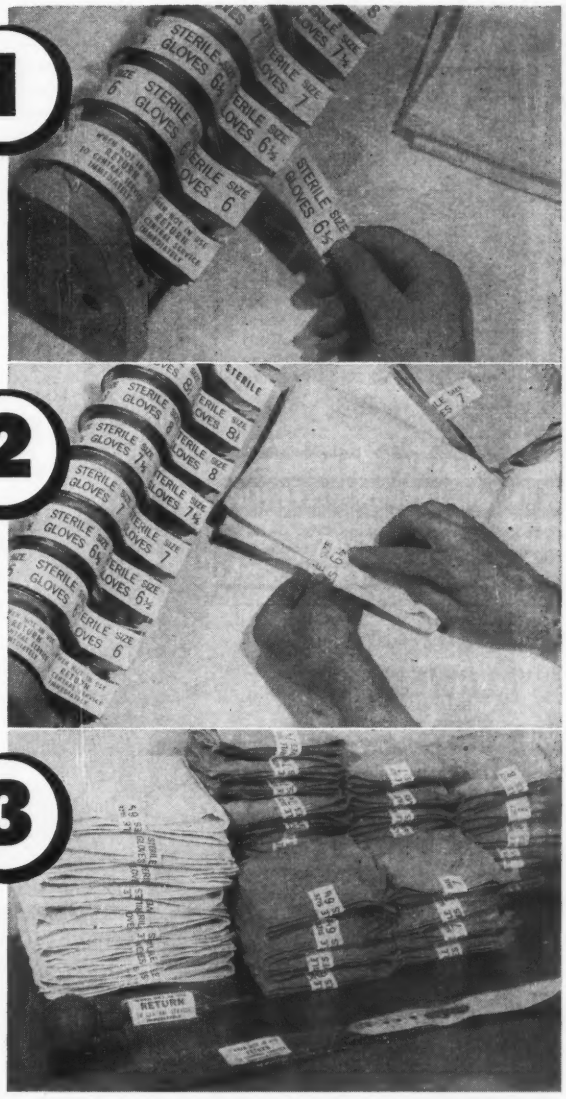

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agement, July 1955, Vol. 80: pp. 75-76.

Ambition, loyalty, and a sense of humor are the essential qualities of a good supervisor, the author states.

Abbott, Esther, R. N. "Let's Examine Ourselves As Central Supply Supervisors." *Hospital Management,* February 1955, Vol. 79: pp. 60-61.

The supervisor's duties and her need for good interdepartmental relations and familiarity with hospital policies are described in this article. A self-evaluation sheet is included.

Burack, David. "Paper Packaging Reduced Our Needle Breakage." *Hospital Management,* April 1955, Vol. 79: p. 48.

Glassine paper container reduced needle breakage. Method of processing is described in this article.

Brackett, Mary E., R.N. "The Central Service Needs Advice from Other Departments." *Hospital Management,* December 1954, Vol. 78: pp. 71-72. (Abstracted in HOSPITAL TOPICS, May 1954, Vol. 32: p. 78, in report from central supply session at the New England Hospital Assembly.)

The advantages of having central supply as a part of nursing service are discussed in this article.

The author points out the need for unusual requests and the need for an advisory group for the department supervisor. The value of central service as a fertile field for work simplification and the reasons why student nurses need orientation in this department are also discussed.

Carroll, Betsey, R.N. "Standardization and the CS Supervisor." HOSPITAL TOPICS, July 1954, pp. 77-78.

The CS supervisor, because of her close contact with the demands, needs, complaints, etc., regarding supplies and equipment, is the logical person to spearhead the standardization program, the author says. She specifies the aid necessary in establishing standardization and where and how to obtain it.

Bergmann, Werner, M.D. "Protection for the Points of Hypodermic Needles." *California Medicine,* April 1955, Vol. 82: p. 325.

The points of needles are often blunted in sterilization because of the contact with the walls of the metal sterilization tray. The author describes a protective holder which he says eliminates this hazard. The holder has slots and notches to hold the needles and may be boiled or autoclaved.

Bertilla, Sister Mary, R.N. "St. Mary's Central Sterile Supply Department." HOSPITAL TOPICS, July 1955, Vol. 33: pp. 85-86.

An account of a central supply unit that coordinates and centralizes the preparation of all sterile and nonsterile material used in the care of patients is given in this article. The value of the dishwasher and other types of equipment and the procedure for ordering and supplying of items are also discussed.

Chandler, Velma L., Ph.D. "Sterilization of Supplies, Part I: Sterilization by Chemicals." HOSPITAL TOPICS, September 1955, Vol. 33: pp. 85-86+.

An informative article with graphic charts describing sterilizing agents, relative resistance of microbes, resting spores, suggested choice of disinfectants for TB technics, survival time of cells exposed to heat, factors affecting efficiency of chemical agents, neutralization of chemical agents by proteins, and the protection of organisms in hinges and crevices by proteinaceous materials.

Chandler, Velma L., Ph.D., Engler, P.L., Horvat, Helen, R.N., and Masci, J.N. "Sterilization of Supplies, Part II: Problem-Solving Clinic." HOSPITAL TOPICS, October 1955, Vol. 33: pp. 97-104.

Symposium of questions and answers on common problems regarding both chemical and steam sterilization.

Cooke, James W. "Equipment Room Has a Place for Everything." *The Modern Hospital,* July 1956, Vol. 87: No. 1, pp. 79-82.

A central equipment room — a subdivision of central supply — combines the advantages of centralized and decentralized storage at Akron City Hospital. Great accessibility and convenience to the nursing personnel has been achieved.

Downing, Alma. "Central Supply Service." *Canadian Nurse,* October 1954, Vol. 50: p. 811.

The author tells how the scope of the central supply has expanded from only sterilization to distribution and sterilization of special and emergency trays. To increase the value of the central supply department in

(Continued on next page)

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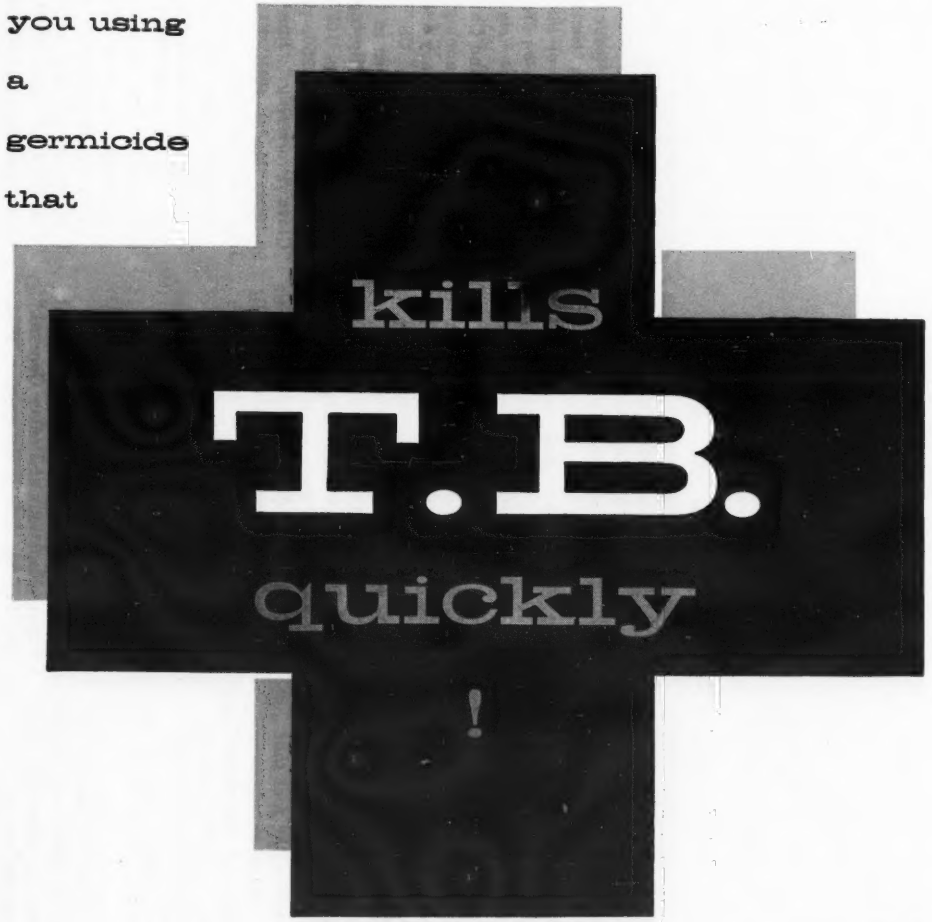

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her hospital, an experiment was carried out in which all dressings were changed by central supply nurses. The importance of this procedure to student teaching and the responsibilities of the central supply supervisor are stressed.

Ferguson, Stanley A. "Color Adds Efficiency." *Modern Hospital*, September 1955, Vol. 85: pp. 65-66.

That color reduces fatigue and stimulates workers is the theme of this article. Other innovations and appliances which have increased the efficiency in the central supply department at the University Hospitals of Cleveland are also included.

Harper, Frank. "Up-To-Date Central Supply Equipment Cuts Hospital's Labor Costs." HOSPITAL TOPICS, August 1955, Vol. 33: p. 77.

Up-to-date equipment reduced by half the usual number of employees in the central supply department. Sending messages, charges, and small articles by pneumatic tube and using heavy-duty dumb waiters have added to greater efficiency.

Heard, Jack S. "Combined Central Supply and Pharmacy Service at the University of California." *The Bulletin American Society of Hospital Pharmacists*, November-December 1955, Vol. 12: pp. 607-611.

The central supply department at the University of California Hospital, Los Angeles, is under the pharmacy department. The essential factor in the successful operation of this department is the central service committee, which includes a representative of each section of the nursing service.

Hildebrandt, John, and Morrow, John L. "Analyzing the Cost of Central Supply." *Hospitals*, November 1955, Vol. 29: pp. 65-67.

The method presented in this article, by a comptroller and an assistant administrator, takes into consideration the fact that demands on central supply vary in accordance with the clinical service concerned. The authors say the cost apportioned to each unit should be based upon that unit's actual use of the central supply.

Hutto, Mabel, R.N. "Cabarrus Memorial Adopts Syringe and Needle Packaging." *Southern Hospitals*, April 1956, Vol. 24: p. 58.

The author states in this article her reasons for favoring syringe and needle packaging using the Steriphane technic.

J. Sister Annunciata. "The Economics of Central Supply." *Modern Hospital*, September 1955, Vol. 85: pp. 64-66. (Abstracted in HOSPITAL TOPICS, May 1954, Vol. 32: P. 79, in report on central supply session at the New England Hospital Assembly.)

Organization, maintenance, and the savings that may be realized through good planning, standardization, and the use of mechanical aids are well covered in this article.

Janke, Otto M. and Briggs, Frank R. "Reorganizing." *Hospitals*, November 1955, Vol. 29: pp. 68-73.

A report on reorganizing the central supply department and remodeling its facilities to fit this change. The goal was reached by the committee approach, attention to work flow, job simplification, and standardization.

Jordan, S.E., Ph.D., and Pfeiffer, C.C., M.D. "Parenteral Fluid Therapy — Basic Principles." *Modern Hospital*, November 1954, Vol. 83: pp. 102+.

The rational use of parenteral fluids requires an appreciation of the distribution of body water and electrolytes. Further information as to distribution of body water, concentration of ions in body fluids, approximation of body needs during water imbalance, physiologic defense mechanisms in acid-base disturbances, and parenteral fluids for clinical use are included in this article. Accompanying figures and tables are good visual aids.

Lang, Philip J., and Redfearn, Samuel E. "Everybody Talks About Prepackaging." *Modern Hospital*, August 1954, Vol. 83: pp. 80-82.

This article, including charts, shows the results obtained by standardization through prepackaging at the Touro Infirmary. The authors observe that few hospitals agree on standardization.

Manning, R.D. and Wilson, Pauline, R.N. "We Made Our Own Glove Powdering Device." HOSPITAL TOPICS, April 1955, Vol. 33: p. 77.

A picture and drawing show how to improvise a powdering device when finances will not permit purchase of similar equipment.

Larson, Carol, R.N. "How Central Supply Functions at Denver General." HOSPITAL TOPICS, August 1954, Vol. 32: pp. 79-82.

Central supply at Denver General services not only its own hospital units but areas outside: Visiting Nurse Association, TB control clinic, fire and police department, and other municipal departments. The author describes the procedure for supplying these areas and discusses the value of the procedure manual, Kardex file with pictures for tray set-up, and the use of requisition forms and stock inventory cards for control of supplies. Staff coverage and working schedule for an average day are outlined.

Markus, Frederick. "Function, Not Beauty Important in CSR Design." HOSPITAL TOPICS, August 1955, pp. 78-79.

Functional design in this department expedites the work flow of production. The need for proper inter-relation of the work stations and the proper planning that results in the utmost efficiency is stated by the author.

Markus, Frederick, and Christie, Mrs. Jean, R.N. "What is Wrong with Conventional CS Planning?" HOSPITAL TOPICS, December 1955, Vol. 33: p. 87.

The shortcomings in the planning of a central supply are given in this article—such as the lack of floor space where needed and permanent placement of equipment in the wrong order, which are very frustrating to the CS supervisor. The planner of a CS should have the general knowledge of production methods, timing, and flow and the aid of the specialist and the "man on the bench" to plan advantageously.

Markus, Frederick, and Christie, Jean, R.N. "Basic CS Planning." HOSPITAL TOPICS, January 1956, Vol. 34: 93-95. "Storage in CS." February 1956, pp. 81-92. "Linen in CS." March 1956, pp. 119-121. "Syringe Processing." April 1956, pp. 107+. "Needle Processing." May 1956, pp. 111-115. "Glove Processing." June 1956, pp. 99-102. "Model CSR Floor Plans." July 1956, pp. 111+.

In this series of articles the concept of substantially reducing the labor element by using production line methods in CS is detailed by an architect and a nurse. Each article contains architectural drawings, showing layout of original method and the new layout with improved

methods of planning, processing, and storage of supplies, to obtain the maximum efficiency in this department.

McNutt, John. Streamlining Central Supply." *Hospital Management*, August 1954, Vol. 78: pp. 66-68.

Taking a good look at the present set-up of central supply and then deciding how it could best be rearranged to better advantage are suggested by the author, chief engineer, Grace Hospital, Detroit.

Noles, Eva, R.N. "How Central Service Grows." *Hospital Management*, June 1956, Vol. 81: pp. 76-78; July 1956, Vol. 82: pp. 80-81.

The author tells in these two articles of the growth of the Roswell Park Memorial Institute central supply department from a small 10'x10' room in 1952 to five large rooms (total area 16'x244'). Before and after drawings of the physical layout are included. The second article deals with the work flow, rotation of duties, processing of syringes, dressing trays, etc.

Morgan, Dorothy M., R.N. "Dressings Research Project, University of Chicago Clinics." HOSPITALS, October 1954, Vol. 28: pp. 88.

The results of a four-month study of surgical dressings are given by the author. The economies achieved through standardization are described.

Ouderkirk, Elizabeth, R.N. "In-Service Program Aids CSS Efficiency." HOSPITAL TOPICS, October 1954, Vol. 32: pp. 97-99.

Efficiency, the author believes, is greatly aided by early morning discussions and classes. The use of volunteer help, written instructions, and posting of the operating schedule all help to make the CS department run more smoothly.

Palmer, David H. "Selection Is the Key to Economy." *Modern Hospital*, May 1955, Vol. 84: No. 5, pp. 63-65.

It is important for the supervisor to be familiar with the product and pass her experience on to the purchasing agent or department, the author emphasizes.

Phillips, Elizabeth C., Gunter, Muriel E., and Gray, Katherine C. "We Have Gone Dry." *Nursing Outlook*, July 1956, Vol. 4: No. 7, pp. 374-378.

A safe, effective, economical procedure for dry-sterilizing syringes and needles and for carrying them in public health nurses' bags is described in this article. The article also includes a list of equipment with costs and personnel required for this technic. The method of preparing syringes is based on the one currently used at the Clinical Center, National Institutes of Health, Bethesda, Md. The method of wrapping needles was originated by the authors and is described with illustrations.

Pendleton, Ruth, R.N. "Department Functions Smoothly Under System of Direct Responsibility to Administration." HOSPITAL TOPICS, September 1954, Vol. 32: pp. 77-79.

Surgery-central supply and the recovery rooms operate as one unit directly under the hospital administrator, rather than the nursing department, at the New England Deaconess, Hospital, Boston. The author tells, in detail, how the present arrangement was put into effect. After this organization was decided upon, the physical layout was designed for it.

Riley, William A. "Something New in Central Supply Layout." *Modern Hospital*, February 1954, Vol. 82: p. 79.

Isometric layout of the central supply department overcomes the hazard of cross-infection and provides for adequate supervision, says the author—an architect. A drawing is included showing the unit at the Burbank Hospital, Fitchburg, Mass. which serves approximately 400 beds.

Sanders, R. Douglas, M.D. and Aikins, James P., M.D. "Notes on the Characteristics, Composition and Care of Rubber Materials Used in Medical Goods." HOSPITAL TOPICS, March 1955, Vol. 33: p. 92.

The authors tell how intelligent care can greatly prolong the useful life of rubber materials. The general characteristics of rubber—neoprene and butadiene styrene—are given along with the points to be observed to obtain the maximum use.

Schafer, Margaret K. "Flask Technic for Sterile Surgical Fluids—a Guide for Planning." HOSPITAL TOPICS, May 1955, Vol. 33: pp. 85-86.

The author gives the recommended technic and the steps required to effectively introduce the use of hermetically packaged sterile distilled water or isotonic sodium chloride solution USP in hospital operating rooms, delivery rooms, and nursing units, instead of sterile water from water sterilizers.

Shafer, Margaret K. "Standardization in the Central Supply Department." HOSPITAL TOPICS, June 1955. Vol. 33: pp. 95+.

The steps to be taken by a central supply supervisor in developing a program of standardization are delineated in outline form. To achieve standardization there first must be a guide. Secondly, law and authority are necessary to enforce the rules. Thirdly, there must be acceptance of the program.

Schafer, Margaret K. "Planning a Central Supply to Meet the Needs of a Modern Hospital." *Hospitals*, June 1954, Part II, Vol. 28: pp. 417-420 (Administrators Guide Issue).

Detailed procedures are given by the author for setting up a CSR to meet the requirements for the modern hospital. Planning, equipment, organization, and operation of this department are of the utmost importance and will provide improved service and patient care.

Skolaut, Milton W., Scigliano, J. A., and Salvino, J.N. "The Central Sterile Supply of a Pharmacy Department." *Bulletin American Society of Hospital Pharmacists*, March-April 1954, Vol. 11: pp. 114-117.

"This Pharmacy Department Operates a Central Sterile Supply." HOSPITAL TOPICS, November 1954, Vol. 30: pp. 81-83.

Central sterile supply at the Clinical Center, National Institutes of Health, is a division of the pharmacy department. The subsections of the central supply division are outlined and described in these two articles. Pictures illustrate some of the work areas.

Skolaut, Milton J., and Salvino, J.N. "A Simple Method for Returning Used Needles." *Hospitals*, April 1955, Vol. 29: pp. 92-94.

A stainless steel pan lined with a cellulose sponge is furnished to all nursing units for the return of needles. This method aids in the processing of the needles, according to the authors.

Summers, Aubrey, R.N. "Pioneer Concept in Central Control." *Hospitals*, August 1954, Vol. 28: pp. 74-76.

This article on central supply service at the Bird S. Coler Memorial Hospital, Welfare Island, N. Y., describes: Master list of supplies, which is revised from time to time; use of requisition forms; checking for missing items; sterilization pro-

(Continued on next page)

cedure; workload; maintenance technics, and the support needed for a smooth-functioning central supply.

Spencer, Paul J. and Coburn, Walter V. "Central Supply at the Crossroads." *Modern Hospital,* May 1954, Vol. 82: pp. 79-82.

The Lowell (Mass.) General Hospital, after two years of planning, decided to put the central supply department on the ground floor of its new building in a spot which was an equal distance to all units. Pictures of work areas and drawings of this central supply are included.

Terrell, Tol. "Pharmacy and Central Supply." *Texas Hospitals,* November 1954, Vol. 10; p. 7+.

This administrator believes that pharmacists are better adapted to central supply administration than any other group, because of the content of their college curriculum today. He tells how the pharmacy-central supply combination functions at Shannon West Texas Memorial Hospital, San Angelo.

Theresa, Sister M., OSF., R.N., M.T. "Hospital Pharmacy and Central Supply Combination." *Hospitals,* November 1955, Vol. 11; p. 7+.

"A Pharmacist Looks at a Central Service-Pharmacy Combination." *Hospital Management,* June 1955, Vol. 79: pp. 76-77.

In these two articles the author tells of her own survey, across the country, concerning this type of combined service. Because of the proximity of the pharmacy and central service in the smaller hospitals, she believes that a pharmacist is the ideal person to be in charge. Statistics show that this type of service is found in 21 percent of hospitals of less than 50 beds; 39 percent of hospitals of 50-99 beds; 79 percent of hospitals of 100-199 beds.

Ustas, Mathew, R.N. "Installing a CS Control System." HOSPITAL TOPICS, December 1954, Vol. 32: pp. 81-84.

A control system is necessary to central supply because it results in a standard for comparison and serves as a means of verification, the author points out. An example of a CSR daily count is included in this article.

"Alarm Guard Against Overflow." *Hospitals.* April 1956, Vol. 30: p. 28.

Described in this article is a simple device to warn personnel when a fluid-collecting bottle is almost full. A plastic bobbin, attached to metal rod, rides in the collecting bottle. The other end is attached to the alarm of an old clock.

"Autoclaving Tape." *Bulletin American Society of Hospital Pharmacists,* May-June 1954, Vol. 11: p. 209.

A method for sealing and identifying autoclaved bundles more easily, faster, and more efficiently with pressure-sensitive tape proved safe, this article states. Other advantages include: reduction of time and labor costs, neat, secure packs, ease of labeling, and convenience and safetty.

"Central Supply Room Aids Department Service at UCLA." HOSPITAL TOPICS, November 1955, Vol. 33: p. 93.

Regular meetings of the central supply department advisory committee promote interdepartmental understanding and better service to the hospital. Pictures illustrate this article.

"Sterile Tray Index Provides Checklist for Central Supply Room." HOSPITAL TOPICS, March 1954, Vol. 32: p. 67.

The booklet, Sterile Tray Index for Hospitals," written by Florence Donahue, R. N. and edited by Evelyn Roberts, R.N. contains 103 sterile setups for the average hospital, 10 of which are pictured with this article.

"Central Supply Room—Alert Supervisor Improves Her Department." HOSPITAL TOPICS, January 1954, Vol. 32: p. 77.

Time-saving and efficiency-promoting measures at the Bishop Clarkson Memorial Hospital, Omaha, Nebr., developed by an alert central supply supervisor, are shown in this picture feature.

"Central Supply Service Discussed at New England Meeting." HOSPITAL TOPICS, May 1954, Vol. 32: pp. 77-79.

Abstracts of lectures on central supply at the New England Hospital Assembly. Subjects discussed: training of personnel, relationship to administration, interdepartmental relationship, and financial implications.

"U. of I. Hospitals Expand Central Supply." HOSPITAL TOPICS, June 1954, Vol. 32: p. 85.

Arrangement of rooms, installation of labor-saving devices, disposable packaging, and expansion of services and a rotating staff increased central supply service efficiency at the University of Illinois

"CS at Cook County Hospital a Major Operation." HOSPITAL TOPICS, February 1955, Vol. 33: pp. 77-79.

Pictures illustrate a few of the work areas of the vast Cook County central supply service. This modernized central supply department services a 3,260-bed hospital.

Hospital-Community Study Planned by University

A $125,587 grant for a five-year study of hospital-community relationships has been received by Michigan State University from the National Institute of Health, U.S. Public Health Service.

First phase of the study will be an examination of hospital-community relationships and classification of those which appear significant.

The research group will then compile and publish a series of case studies on selected hospitals.

Scheduled for investigation are the sociological aspects of hospital financing and building programs, and the roles of auxiliary organizations, volunteer and part-time hospital workers and aides, nurses, doctors, administrators, and civic and governmental agencies.

Leaders of the project are Walter E. Freeman Ph.D., of the community services staff of Continuing Education Service, and Jay W. Artis, Ph.D., department of sociology and anthropology.

Similar hospital studies are in progress at Mississippi State College, Louisiana State University, and the University of Texas.

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One of the first X-ray tubes used by Wilhelm Konrad Roentgen has been placed on permanent exhibition at the U.S. National Museum, Smithsonian Institution, Washington, D.C.

The tube, Roentgen's third, was purchased from a private owner in Germany by General Electric's x-ray department.

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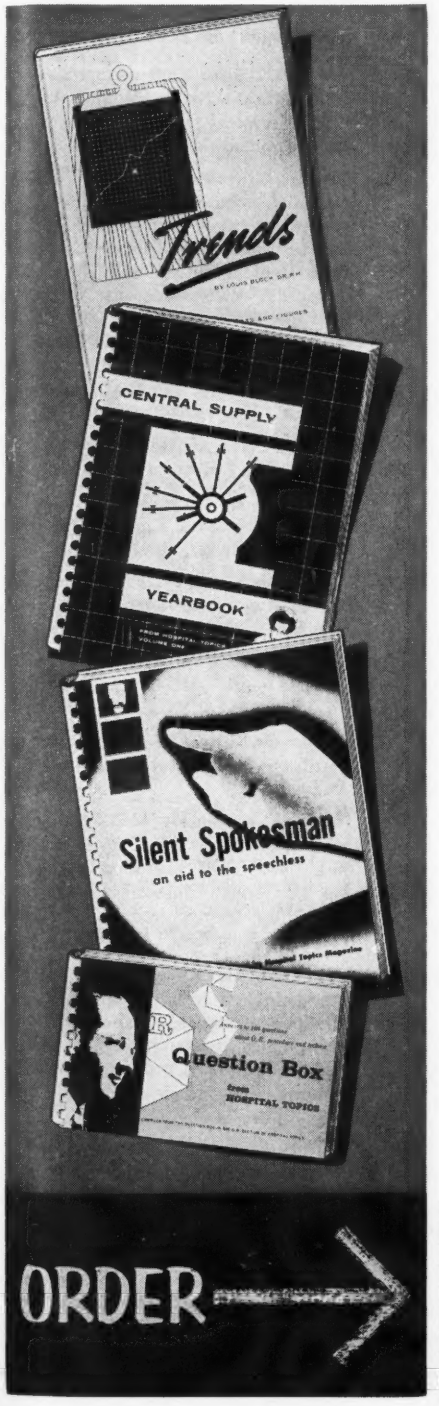

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CENTRAL SUPPLY YEARBOOK FROM HOSPITAL TOPICS

Volume I. HOSPITAL TOPICS in 1952 became the first hospital publication to recognize the importance of the central supply department by establishing a special section in the magazine for its personnel. Since then every issue has carried practical articles which help the CSR supervisor and her staff to do a better job. From those articles the editors have carefully selected the ones which appear in this yearbook — the first of a series. They deal with every major CSR problem, whether it's methods of sterilization, inservice training, or work simplification. Among the authors: Margaret K. Schafer, R.N., Frederick Markus and Jean Christie, R.N., Edna Prickett, R.N., Betsey Carroll, R.N., Velma Chandler, Ph.D. **$1.50**

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PERSONALLY SPEAKING

(Continued from page 87)

Margaret Mueller — is assistant chief, nursing education, VA Hospital, Richmond, Va. She formerly held a similar position at Marion, Ill.

Ellie Murphy—has been appointed assistant chief, nursing education, VA Hospital, North Little Rock, Ark.

Alice O'Leary—is assistant chief, nursing education, Marion, Ill.

Irma Olson—has been named assistant chief, nursing education, VA Hospital, Fort Howard, Md. She had held a similar position at Boston, Mass.

Helen Phillips—is chief, nursing service, VA Hospital, Butler, Pa. She was formerly assistant chief, nursing service, Walla Walla, Wash.

Lucille Sullivan—has been named assistant chief, nursing education, VA Hospital, Providence, R. I. She was formerly educational director, St. Joseph's Hospital School of Nursing, Providence.

Anna Tock—is now assistant chief, nursing service, VA Hospital, Birmingham, Ala.

Mary Tomasek—has been assigned assistant chief, nursing service, Brecksville (Ohio) VA Hospital.

John Townley—has been appointed assistant chief, nursing service, VA Hospital, Biloxi, Miss.

Phyllis Trautman — is assistant chief, nursing education, Newington Division, West Haven (Conn.) Hospital.

Margaret Walsh—has been named chief, nursing service, VA Hospital, Sunmount, N. Y. She had been assistant chief, nursing service, Madison, Wis.

Julia Welsh—is assistant chief, nursing service, VA Hospital, Reno, Nev.

Sadie Wheless—has been assigned chief, area nursing service, office of area medical director, St. Louis, Mo. She was formerly chief, nursing service, Durham, N. C.

Deaths

Reuel A. Benson, M.D.—78, senior director of pediatrics, Flower-Fifth Ave. Hospitals, New York City, died August 6.

A. J. Carlson, M.D.—81, nutritions expert in the feeding of millions of Europeans after World War I, died Sept. 2. He was consultant to the Army on packaged rations during World War II, and recipient of the AMA distinguished service gold medal.

William Sohier Bryant, M.D.—95, a leading New York City ear specialist, died June 26. He had been associated with Post-Graduate, Manhattan State and Presbyterian Hospitals, New York, N.Y., and was the author of "Anatomy and Physiology of the Ear" and other works on the pathology of the ear and throat.

Fred G. Carter—former administrator, St. Luke's Hospital, Cleveland, Ohio, died recently.

Nathan Folkman, M.D.—48, president-elect, Kings County Surgical Society, died August 8. He was associate surgeon, Prospect Heights and Cumberland Hospitals, Brooklyn, and a member, surgical staff, Swedish Hospital in Brooklyn, N.Y.

W. L. Gibbs—business manager, Central State Griffin Memorial Hospital, Norman, Okla., for 43 years, died recently.

Louis Greenwald, M.D.—67, blood specialist, died recently. He was associate professor of medicine and associate attending physician, New York Medical College and Fifth Ave. Hospitals; consultant in medicine, Metropolitan and Bird S. Coler Hospitals, New York City; and attending physician, Department of Medicine and Hematology, Manhattan General Hospital.

J. H. Hargon — administrator, Leeds (Ala.) Hospital, died recently.

Thomas H. Haynes—73, administrator for 20 years, Knoxville (Tenn.) General Hospital, died July 16.

John A. Jones—former administrator, Piedmont Memorial Hospital, Greensboro, N.C., died recently.

Charles J. Kaufman, M.D. — 59, head, tuberculosis service, VA Hospital, Castle Point, N.Y., died recently.

John P. Kelly—55, superintendent, Scranton (Pa.) State Hospital, died August 10.

Moses Keschner, M.D.—80, associate neurologist, Mount Sinai Hospital, New York City, died August 31. He was also consulting neurologist to Montefiore, Sydenham and Maimonides Hospitals, New York City.

L. Winfield Kohn, M.D.—68, former chief, clinic of gastroenterology, Medico-Chirurgical College, Philadelphia; chief, gastro-intestinal department, Temple University Hospital, Philadelphia, and chief, gastro-intestinal clinic, Lebanon Hospital, the Bronx, died recently.

L. Harry Newburgh, M.D.—73, internist and diabetes expert, died July 17. He was a charter member, American Diabetes Association.

Sophie Spitz—46, director, pathology department, New York Infirmary died August 10. She was also assistant attending pathologist, Memorial Center for Cancer and Memorial Diseases, New York.

"Better hurry, dear. Visiting hours are almost over."

(Continued from page 117)

Suggest Viral Etiology of Hodgkin's Disease

Study Fails to Reveal Virus-like Structures

A possible viral etiology of Hodgkin's disease has been suggested. Since few studies have been reported on the electron microscopy of the cells of the reticulo-endothelial system, lymph-node tissue sections were examined from a series of patients with Hodgkin's disease, lymphosarcoma, and other related diseases.

Repeated examinations failed to reveal any virus-like structures. A careful study of sections indicates that the reticulum cell is the probable precursor of the Reed-Sternberg cell. **—Walter J. Frajola, Marie H. Greider and Charles A. Doan, Columbus, Ohio.**

Study Reasons for Hemolytic Reactions

Technical and Clerical Errors Account for Most

In a study of 20,000 patients receiving 63,816 bottles of blood, 87 hemolytic reactions were attributed to clerical error and 720 to technical error.

Unlabeled specimens were observed 50 times; wrongly labeled specimens, 29 times. Eight errors in administration in the laboratory occurred when the pressure of work was particularly high.

It is evident that no matter how accurately laboratory tests may be performed, clerical errors can undo this accuracy and make for disaster. **—John Wallace, M. C. and M. Love, Regional Director Glasgow and West of Scotland Blood Transfusion Service, Glasgow, Scotland.**

Study Red-Cell Survival Rate

Two Basic Mechanisms Account for Disappearance

The technic using Cr 51 for study of red-cell survival has the disadvantage of disappearing from the circulation more rapidly than originally tagged erythrocytes.

There are two basic mechanisms which account for the disappearance of red cells from the circulation: (1) a determinate life span, which in the normal individual approximates 120 days, and (2) a mechanism which eliminates cells in a random or exponential fashion. Increased rates of red-cell disappearance can be detected with Cr 51 erythrocyte survival studies, but the pattern of the curve is determined by a composite of these two factors — cell aging and random loss of cells.

A nomographic approach can be used to estimate the relative importance of these factors. It allows for a daily approximation of the rate of red-cell production.—**Allyn B. Ley and Klaus Mayer, New York City.**

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Scanning the News

(Continued from page 7)

Infants Can Be Given Solid Food Early

Walter W. Sackett, Jr. M.D., Miami, Fla. advocates introducing solid foods into an infant's diet within the first few days of life.

Writing in the September issue of *GP*, the doctor maintains that mothers should have their babies conform to adult lives, rather than make the family adjust to the demands of the baby.

Along with the use of solid foods, Dr. Sackett advocates a six-hour feeding interval.

British Plan Control Of Humpbacked African Fly

A humpbacked fly, transmitter of eye disease in West Africa, East Africa, Mexico, Dutch Guiana, and Guatemala, can now be brought under control, the British believe.

The disease, called onchocerciasis, is caused by a microscopic worm. The blood-sucking fly ingests the worms and passes on the disease. An afflicted person develops lumps on the skin and will become blind if the worm reaches the eye chambers.

Geoffrey Crisp, Ph.D., entomologist, believes the fly can be controlled with a 10 percent solution of DDT in an oil base, lethal to fly larvae.

A three-year fly eradication project in collaboration with the Gold Coast government is planned.

Antibiotics May Help Keep Fish Fresh Longer

Fish may be kept sea-fresh for much longer periods of time with the use of antibiotics, according to the United Nations Educational, Scientific and Cultural Organization.

Fourteen different antibiotics have been used in tests in California. They show varying degrees of efficiency.

Successful tests using antibiotics have been made in Denmark, Japan, the Netherlands, Norway, and Britain.

Pennsylvania Hospital Installs Movie X-Rays

Pittsburgh's first cineradiography machine equipped with an image amplifier has been installed at Western Pennsylvania Hospital.

More detailed motion picture x-rays are made possible by this machine, one of less than a dozen in use in the United States.

The unit at West Penn consists of a fluoroscope topped by an image amplifier, to which a 35 mm. camera is attached, resulting in a more compact machine than previous models.

Cineradiography is said to be particularly useful in diagnosing certain types of heart disease, digestive disorders, and orthopedic problems.

Personality Helps Determine Effect of Drugs

Personality plays a role in determining the extent of effect of drugs, say two researchers, National Institute of Mental Health.

Conan Koretsky and Ogretta Humphries reported this conclusion to the American Psychological Association after testing persons of varying temperaments.

Mechanical Kidney Can Be Used To Wash Barbiturates from Body

A mechanical kidney has been used successfully to wash barbiturates from the human body.

Leonard B. Berman, M.D., Harold J. Jeghers, M.D., George E. Schreiner, M.D., and Arthur J. Pallotta reported on it in a recent issue of the *Journal of the American Medical Association.*

The process of passing the blood through the machine to be washed and sent back into the body is important because more than 15,000 patients annually overdose themselves with barbiturates.

CORRECTION

In the September issue, Sister Mary Philippa was incorrectly identified as new administrator, French Hospital, San Francisco. She is still administrator of St. Mary's Hospital, San Francisco. The new administrator of French Hospital is Mr. Norman Thompson. The editors regret the error.

clinical notes

Radioiodine Thyroid Tests

The most precise tests for the diagnosis of toxic diffuse goiter are the six-hour thyroidal-collection tests, the thyroidal iodide clearance test, and the conversion ratio, write McConahey, Owen, and Keating in the *Journal of Clinical Endocrinology* 16:724-734 (June, 1956).

Tracer doses of radioiodine were given to 208 patients in whom various thyroid disorders had been diagnosed and to 181 euthyroid patients who served as controls. Ninety-two of the 208 had toxic diffuse goiter, 46 had adenomatous goiter without hyperthyroidism, 13 had myxedema, and 38 were initially suspected of having toxic diffuse goiter but were later judged to be euthyroid.

Seven diagnostic laboratory procedures employing radioiodine were evaluated in terms of their economy, the time required, and the ease of administration and operation, as well as diagnostic precision.

The six-hour thyroidal collection test is the simplest and the most rapidly performed and requires the least radioactivity, they say; consequently it is the best for the requirements of a routine radioiodine test. Only two tests, the six-hour and the 24-hour thyroidal-collection test, were of value in the diagnosis of myxedema. None of the seven tests was decisive in determining whether a patient with a nodular goiter had or did not have hyperthyroidism.

Increase in Hepatitis

There apparently has been an actual increase in the incidence of hepatitis, along with improvement in the reporting of cases, Sherman and Eichenwald write in *Annals of Internal Medicine* 44: 1049-1069 (June, 1956) basing their statement on a geographic classification of reported case data by the state and region by year.

The number of reported cases of viral hepatitis, comprising infectious and serum hepatitis, has increased during the four years of the study, they point out, with the peak incidence occurring in the late winter or early spring months in all regions of the United States.

The seasonal low has consistently occurred during the summer, and this has also been observed in the Scandinavian countries and England. This cyclic behavior emphasizes the epidemic nature of infectious hepatitis. Seasonal distribution of the recorded deaths in the United States, however, shows little variation during the year, suggesting that deaths may be due mainly to serum hepatitis.

Data obtained on incidence by age and sex indicate that the highest incidence occurs in persons under 15 years of age and that both sexes are equally susceptible. The recorded death data show increasingly higher rates with increasing age, indicating that hepatitis is more severe in older age groups or that the incidence of serum hepatitis increases in these age groups.

There is an excess of deaths in females in the age groups between menarche and menopause and an excess of deaths in males in the age groups over 50 years. The reasons for these differences are not apparent.

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Liquid Antacid

Robalate (R) Liquid has been released by the A. H. Robins Co. Like Robolate tablets, Robalate Liquid is an antacid for treatment of peptic ulcer.

Each 5 cc. contains dihydroxy aluminum aminocetate, N.N.R., — 0.5 Gm. (7½ gr.).

The preparation is available in 12-oz. bottles only.

Treatment of Anemia

Neo-Ferinex Plus (a product of the Paul Plessner Co.) is a new preparation for the prevention and treatment of all anemias amenable to oral nutritional therapy.

Each tablet provides 150 mg. ferrous sulfate; 100 mg. liver dessicated N.F.; 100 mg. stomach substance; 0.5 mg. folic acid; 50 mg. ascorbic acid; 0.5 U.S.P. Units vitamin B_{12} with intrinsic factor concentrate; 2.0 mcgm. vitamin B_{12} (crystalline), and 3 gr. oyster shell calcium.

Tablets are supplied in bottles of 50, 100, and 150.

Antihypertensive-Sedative

Elixir Butiserpine, a new liquid dosage form of the antihypertensive and sedative, Butiserpine, has been introduced by McNeil Laboratories.

It combines Butisol sodium with reserpine, and is suggested by the manufacturer for treatment of mild to moderate essential hypertension, and for a mild sedative and tranquilizing effect in such conditions as coronary occlusion, angina pectoris, congestive heart failure, the anxiety neuroses, and insomnia.

No hazard of accumulation is involved in prolonged dosage, the manufacturer says.

The product comes in 12 oz. bottles.

Barbiturate Antagonist

Mikedimide (methetharimide), a barbiturate antagonist, is available from the Panray Corp.

No signs of toxicity have been observed, according to the manlfacturer, who recommends it for use wherever barbiturate are used extensively.

Vitamin K Tablets

Mephyton compressed tablets, a vitamin K preparation in oral form which is said to be chemically identical to naturally occurring vitamin K_1, has been released by Sharp & Dohme, Division of Merck & Co.

According to the manufacturer, Mephyton produces reversal of hypoprothrombinemia, caused by a deficiency of vitamin K in the diet, or interference with its absorption.

The product is also recommended for administration to a mother prior to delivery or to the infant after delivery, to prevent hemorrhage in the infant.

Tablets are available in bottles of 100.

New Container

Furacin Soluble Dressing, Eaton's topical antibacterial agent, is now packaged in a 5-oz. plastic container instead of a 4-oz. glass jar.

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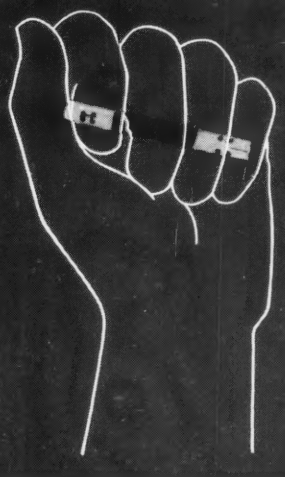

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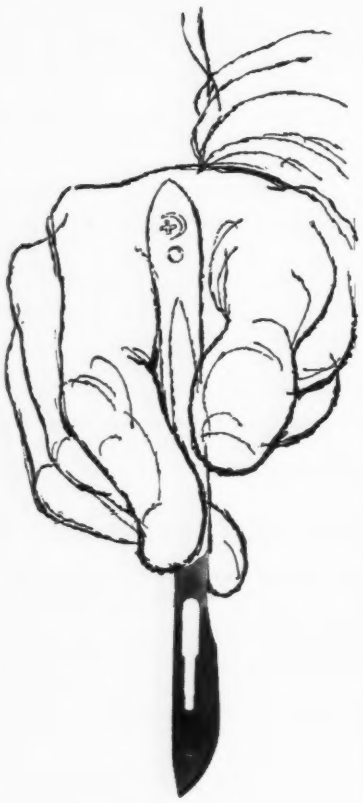

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Administrators' Problems Subject of Study

Problems of hospital administrators throughout the country will be reviewed and a model code of hospital law will be drawn up in a project to be supported by a $180,000 grant from the U.S. Public Health Service.

Cooperating in the project are the Graduate School of Public Health of the University of Pittsburgh and the American Hospital Association.

Attorneys John F. Horty and Samuel G. Shahade, Johnstown, Pa., are directors of the two-year project, first of its kind to be attempted on a national scale.

Aims of the project include the development of a model constitution and bylaws to be used by administrators and governing boards of hospitals, and a handbook for administrators.

The handbook will contain sections on public health laws, privileged communications, vital statistics, Social Security, taxation of hospital property, narcotics and others.

Research Grants Announced By Cerebral Palsy Fund

The United Cerebral Palsy Research and Educational Foundation, Inc., has made 60 grants this year totaling $500,000 to scientists and teachers in 45 research institutions and universities.

Fred A. Mettler, M.D., and Harry Grundfest, M.D., at Columbia University, and Carlton C. Hunt, M.D., at Yeshiva University have received grants for studies in the basic structure and function of the brain.

A study of the lack of oxygen as a factor in brain damage is being done by Peter Gruenwald, M.D., Margaret Hague Maternity Hospital, Jersey City, N.J., with one of the grants.

Educational grants include undergraduate fellowship programs at the American Occupational Therapy Association and the American Physical Therapy Association, and a postgraduate course in cerebral palsy for physicians and therapists at Columbia University.

Medical School Enrollments Reach Record Number

Men and women enrolled in medical schools approved by the American Medical Association total 28,639, according to the AMA.

This record number includes students in 76 four-year school and in six schools providing the first two years of medical training.

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